

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03368

CERTIFICATE OF DEATH

Reg. Dist. No.

3397

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>				TOWN <u>MARDELA</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSP</u>				STREET ADDRESS (If rural give location) <u>MAIN ST</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>GEORGE</u> (Middle) <u>WASHINGTON</u> (Last) <u>BAKER</u>				(Month) <u>MAR</u> (Day) <u>4</u> (Year) <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JUNE 23, 1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JACOB W. BAKER</u>				14. MOTHER'S MAIDEN NAME <u>AGUSTA KNOWLES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-16-9270</u>		17. INFORMANT & ADDRESS <u>MR CARL BAKER</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Pulmonary Congestion & Edema (acute)</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO <u>Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Chronic Myocarditis</u>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>FEB 18, 1956</u> , to <u>MARCH 3, 1956</u> , that I last saw the deceased alive on <u>MARCH 3, 1956</u> , and that death occurred at <u>4:30</u> M., from the causes and on the date stated above.							
SIGNATURE <u>NE Spothoach MD</u>				DATE SIGNED <u>MAR 3, 1956</u>			
ADDRESS (Street, city, town, state) <u>MD, Delaplace, Maryland</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3/7/56</u>		NAME OF CEMETERY OR CREMATORY <u>SAINT MARKS</u>		LOCATION (City, town, of county) (State) <u>LAUREL, DELAWARE</u>	
24. REC'D BY REGISTRAR <u>MAR 7 1956</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Paul J. Smith, Shapstone, MD</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

Reg. Dist. No.

3398

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>15</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gen. Hn Hosp</u>		d. STREET ADDRESS <u>1031 Lake St</u>	
3. NAME OF DECEASED (Type or print) First <u>Laurence</u> Middle <u>L.</u> Last <u>Benson</u>		4. DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/12/11</u>
9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Laurence Benson Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Sadie Jacobs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Mary Benson</u>		Address <u>Salisbury</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>410X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Combined right & left heart failure</u> (c) <u>Rheumatic mitral & aortic valvular disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 yr.</u> <u>1 year</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 11. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/14/1956</u> , to <u>3/14/1956</u> , that I last saw the deceased alive on <u>3/14/1956</u> , and that death occurred at <u>3/14/1956</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
22. ACTUAL SIGNATURE M.D.			
23. PHYSICIAN'S NAME (Type)			
24. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
25. DATE THEREOF <u>3-19-56</u>			
26. NAME OF CEMETERY OR CREMATORY <u>Green Forest Mem. Cem.</u>			
27. LOCATION (City, town, or county) (State) <u>Salisbury MD</u>			
28. FUNERAL DIRECTOR'S SIGNATURE <u>Booker H. West</u>			
29. ADDRESS <u>Salisbury MD</u>			
30. REC'D BY REGISTRAR DATE <u>3-20-56</u>			
31. REGISTRAR'S SIGNATURE <u>Mary H. Holloman</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 22 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03370

3399

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>WORCESTER</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>NEWARK</u>		<u>23X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>LIZZIE</u>				<u>BOWSER</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>Copied</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>8-8-1900</u>	
9. AGE last birthday <u>55 yrs.</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Months <u>7</u>		Days <u>7</u>		Hours <u>7</u>		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>NEWARK, WORCESTER CO. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>ARA SPENCE</u>				14. MOTHER'S MAIDEN NAME <u>AMANDA JOHNSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>JAMES BOWSER, NEWARK, MD.</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
490X IMMEDIATE CAUSE (A) <u>Pneumococcal meningitis</u>				5 days			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Acute Pneumonia</u>				5 days			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/11</u> , 19 <u>56</u> , to <u>3/15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/15</u> , 19 <u>56</u> , and that death occurred at <u>7:45</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>William H. Gray</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>			
DATE <u>3/17/56</u>				DATE SIGNED <u>3/17/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3-19-56</u>		NAME OF CEMETERY OR CREMATORY <u>CEDAR CHAPEL CEM</u>		LOCATION (City, town, or county) (State) <u>NEWARK, WORCESTER CO. MD.</u>	
24. REC'D BY REGISTRAR <u>Mary J. Holloway</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. STEWART</u>		ADDRESS <u>Stewart Funeral Home, Salisbury, Md.</u>	

CERTIFICATE OF DEATH

3890

REG. OFF.

1. DEATH OF INMATE

NAME
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
MARRIAGE
EDUCATION
OCCUPATION
RELIGION
MILITARY SERVICE
PREVIOUS ILLNESS
CAUSE OF DEATH
MANNER OF DEATH
PLACE OF DEATH
DATE OF DEATH
TIME OF DEATH
SIGNATURE OF REGISTRAR
DATE OF REGISTRATION

2. DEATH OF NON-INMATE

NAME
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
MARRIAGE
EDUCATION
OCCUPATION
RELIGION
MILITARY SERVICE
PREVIOUS ILLNESS
CAUSE OF DEATH
MANNER OF DEATH
PLACE OF DEATH
DATE OF DEATH
TIME OF DEATH
SIGNATURE OF REGISTRAR
DATE OF REGISTRATION

3. DEATH OF NON-INMATE

NAME
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
MARRIAGE
EDUCATION
OCCUPATION
RELIGION
MILITARY SERVICE
PREVIOUS ILLNESS
CAUSE OF DEATH
MANNER OF DEATH
PLACE OF DEATH
DATE OF DEATH
TIME OF DEATH
SIGNATURE OF REGISTRAR
DATE OF REGISTRATION

4. DEATH OF NON-INMATE

NAME
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
MARRIAGE
EDUCATION
OCCUPATION
RELIGION
MILITARY SERVICE
PREVIOUS ILLNESS
CAUSE OF DEATH
MANNER OF DEATH
PLACE OF DEATH
DATE OF DEATH
TIME OF DEATH
SIGNATURE OF REGISTRAR
DATE OF REGISTRATION

5. DEATH OF NON-INMATE

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PLACE OF BIRTH
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CAUSE OF DEATH
MANNER OF DEATH
PLACE OF DEATH
DATE OF DEATH
TIME OF DEATH
SIGNATURE OF REGISTRAR
DATE OF REGISTRATION

RECEIVED

BUREAU V. 5

MAR 19 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3451 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03371
Reg. Dist. No. 322

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parsonsborg</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>at home R F D # 1 Parsonsborg, Md.</u>		d. STREET ADDRESS <u>R F D # 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Linwood</u> Middle <u>Brown</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>19 56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1902</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labar</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Ba.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>?</u>	
14. MOTHER'S MAIDEN NAME <u>3.</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>213-22-8112</u>		17. INFORMANT <u>C Echel Scott Willard Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		(County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Earl L Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-10-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-18-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>		22d. LOCATION (City, town, or county) <u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. West</u>		ADDRESS <u>Salisbury Md</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	
DATE <u>3-28-56</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7,9, Film 101-3-19-56 et

03372

Gilmore & Ellis

3400

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Greenbackville COUNTY Va.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbackville 83X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) THOMAS First FRANCIS Middle BURNS Last				4. DATE OF DEATH Month March Day 11 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-5-1877	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Gov.		10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Francis Thomas Burns				14. MOTHER'S MAIDEN NAME Anna M. McLaugholin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Spanish American War		16. SOCIAL SECURITY NO.		17. INFORMANT 508 Philadelphia Pike Wilmington, Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thromboses 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-7 , 19 56 to 3-11 , 19 56 , that I last saw the deceased alive on 3-11 , 19 56 , and that death occurred at 5:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wilber R. Ellis, Jr. M.D.				ADDRESS (Street, city or town, state) Medical Center		DATE SIGNED March 12 1956	
PHYSICIAN'S NAME (Type) Dr. Wilber R. Ellis Jr. M.D. Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 1956		22c. NAME OF CEMETERY OR CREMATORY Catholic		22d. LOCATION (City, town, or county) (State) R. D. Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. W. PIPPIN & SON FUNERAL HOME - ELKTON MD.				24a. REC'D BY REGISTRAR DATE 3/5/56		24b. REGISTRAR'S SIGNATURE Mary Holloway	

W

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY	
10:00 PM		HEART DISEASE		SUICIDE		CORONARY THROMBOSIS		CORONARY THROMBOSIS		CORONARY THROMBOSIS		CORONARY THROMBOSIS		CORONARY THROMBOSIS		CORONARY THROMBOSIS	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY	
10:00 PM		HEART DISEASE		SUICIDE		CORONARY THROMBOSIS		CORONARY THROMBOSIS		CORONARY THROMBOSIS		CORONARY THROMBOSIS		CORONARY THROMBOSIS		CORONARY THROMBOSIS	

BUREAU V. S.

MAR 15 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3452 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03373

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>00</u>				d. STREET ADDRESS <u>X</u>			
3. NAME OF DECEASED (Type or print) <u>Baby Boy Chatham</u>				4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1-12-56</u>	9. AGE (in years last birthday) yrs. <u>2</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>11</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Martha Chatham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Martha Chatham</u> Address <u>Tyaskin, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3-27-56</u>			
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tyaskin Cemtery</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Messick</u>		ADDRESS <u>Bivalve, Maryland</u>		24a. REC'D BY REGISTRAR <u>2</u>			
24b. REGISTRAR'S SIGNATURE <u>Mary W. Hallaway</u>		24c. REGISTRAR'S SIGNATURE <u>2</u>		24d. REGISTRAR'S SIGNATURE <u>1956</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, and cause of death. The form is partially filled out with handwritten text.

NAME: *John Doe*
AGE: *45*
SEX: *M*
RACE: *W*
CAUSE OF DEATH: *Heart Disease*

BUREAU V. 2

APR 2 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03374
03374

Dr. Hearn

3453

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Schumaker Lane (R.D. # 3)		d. STREET ADDRESS Schumaker Lane (R.D. # 3)	
3. NAME OF DECEASED (Type or print) LUCY ANN COLLINS		4. DATE OF DEATH Month March Day 1 st Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1898
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 5 Days 16 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at own Home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Huffman		14. MOTHER'S MAIDEN NAME Annie Singns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mr. John W. Owens (Son)		Address Salisbury, Maryland Schumaker Lane (R.D. # 3)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embolus in heart vessels (clotting) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) arteriosclerosis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/24/56 to 3/1/56 , 19 56 , that I last saw the deceased alive on 2/24/56 , 19 56 , and that death occurred at 8:45 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) North Division St. Salisbury, Maryland DATE SIGNED Mar. 2 1956			
ACTUAL SIGNATURE Carrie I. Hearn M.D.		24a. REC'D BY REGISTRAR Mary H. Holloway	
PHYSICIAN'S NAME (Type) Dr. Carrie I. Hearn M.D.		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 4, 1956	
22c. NAME OF CEMETERY OR CREMATORY Owens Family Cemetery		22d. LOCATION (City, town, or county) (State) Near St. Luke (Fruitland Md.)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	

BUREAU V. S.

MAR 5 1956

RECEIVED

3454

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron				c. LENGTH OF STAY IN lb 6 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00				d. STREET ADDRESS X			
3. NAME OF DECEASED (Type or print) First Dennis Middle Julian Last Carr				4. DATE OF DEATH Month March Day 28 Year 1956			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 23, 1897	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months 28 Days 19 Hours 56 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Carr				14. MOTHER'S MAIDEN NAME Sarah Fisher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Daisy Carr		Address Hebron, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from March 20, 1957 , to March 22, 1957 , that I last saw the deceased alive on March 22, 1957 , and that death occurred at 3:20 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William Emerich				ADDRESS (Street, city or town, state) Hebron, Md.			
PHYSICIAN'S NAME (Type) William Emerich				DATE SIGNED March 29-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 30, 1956		22c. NAME OF CEMETERY OR CREMATORY Vienna Cemetery		22d. LOCATION (City, town, or county) (State) Vienna, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE 3-30-56		24b. REGISTRAR'S SIGNATURE Mary W. Holloray	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 2 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3455 CERTIFICATE OF DEATH

03376

Dr. Robbins

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Powellville</u>				TOWN <u>Powellville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.D. # 1 Pittsville</u>				STREET ADDRESS (If rural give location) <u>R.D. # 1 Pittsville</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>NELLIE</u> <u>LAURA</u> <u>COLLINS</u>				<u>Mar.</u> <u>14</u> <u>th</u> <u>19</u> <u>56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>July 18, 1916</u>	<u>39</u> yrs.	Months <u>7</u>	Days <u>26</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House Work</u>		<u>at own home</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>Levin H. Collins</u>				14. MOTHER'S MAIDEN NAME <u>Sadie Hales</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
						<u>Mrs. Sadie W. Collins (Mother) R.D. # 1 Pittsville - Powellville, Maryland</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
154X IMMEDIATE CAUSE (A) <u>Carcinoma, Recto-Sigmoid Colon &</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized metastatic - Carcinoma</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Polyposis Recto et Sigmoid</u>				<u>6-7 yrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>48</u> , to <u>Mar 14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Mar 13</u> , 19 <u>56</u> , and that death occurred at <u>4:10</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>Helen M. Berlin</u>				ADDRESS (Street, city, town, state) <u>M.D. Berlin, Maryland</u>		DATE SIGNED <u>Mar. 18 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar. 18, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Collins Family Cemetery</u>		LOCATION (City, town, or county) (State) <u>Near Powellville, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
DATE <u>MAR 21 1956</u>							

CERTIFICATE OF DEATH

Date of Death

Place of Death

Usual Residence of Deceased

Age of Deceased at Date of Death

Sex of Deceased

Color

Marital Status

Occupation

Education

Religion

Usual Place of Birth

Usual Date of Birth

Usual Date of Death

Usual Date of Burial

Usual Date of Interment

Usual Date of Cremation

Usual Date of Disposition

Usual Date of Burial

Usual Date of Interment

Usual Date of Cremation

Usual Date of Disposition

Usual Date of Burial

Usual Date of Interment

Usual Date of Cremation

Usual Date of Disposition

Usual Date of Burial

Usual Date of Interment

Usual Date of Cremation

Usual Date of Disposition

Usual Date of Burial

Usual Date of Interment

Usual Date of Cremation

Usual Date of Disposition

Usual Date of Burial

Usual Date of Interment

Usual Date of Cremation

Usual Date of Disposition

Usual Date of Burial

Usual Date of Interment

Usual Date of Cremation

Usual Date of Disposition

Usual Date of Burial

Usual Date of Interment

Usual Date of Cremation

Usual Date of Disposition

BUREAU V. S.

MAR 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has signed by the attending physician and completed in by the funeral director. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 20 Film G194 3-16-56 ams

3491
CERTIFICATE OF DEATH

Reg. Dist. No. 03327

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury		c. LENGTH OF STAY IN lb Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) 82 Peninsula General Hospital		d. STREET ADDRESS 116 W. Locust	
3. NAME OF DECEASED (Type or print) First Christena Middle Catherine Last Conrad		4. DATE OF DEATH Month March Day 6 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1876
9. AGE (In years last birthday) yrs. 79		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J.K.Hinkle		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Benjamin Conrad, Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Inanition DUE TO (c) Fracture, Rt hip		INTERVAL BETWEEN ONSET AND DEATH 1 wk > 6 mos 6 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell while going to bathroom	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. Feb 15 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Salisbury Wic Md.	
21. I certify that I attended the deceased from 2/18 , 19 56 , to 3/6 , 19 56 , that I last saw the deceased alive on 3/5 , 19 56 , and that death occurred at 9 A . M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Rufus S. Gardner, Jr.		ADDRESS (Street, city or town, state) DATE SIGNED 321 S. D.V. St. Salisbury, Md. 3/6/56	
PHYSICIAN'S NAME (Type) RUFUS S. GARDNER, JR.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-8-56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olive		22d. LOCATION (City, town, or county) (State) Delmar, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE W.S. Gamm Co - Delmar, Md		24a. REC'D BY REGISTRAR DATE 3/9/56	
24b. REGISTRAR'S SIGNATURE Mary W. Hollaway			

MAR 9 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03378

3402

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Worcester</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Whaleysville</u>	23x-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Hill Sanitarium</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (Type or Print) <u>Florence Whaley Dale</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>March 17, 1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Sept. 14, 1871</u>
9. AGE last birthday <u>84</u> yrs.		10. AGE last birthday IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>E. Thomas Whaley</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S ADDRESS: <u>Mrs. Mary Mason, Berlin, Md</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
442X IMMEDIATE CAUSE (A) <u>Cardiovascular renal disease</u>			
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO			
STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-1</u> , 19 <u>56</u> to <u>3-17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-15</u> , 19 <u>56</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Flora Lush</u>		DATE SIGNED <u>March 18-56</u>	
ADDRESS <u>Salisbury, Md</u>		M.D. <u>Salisbury, Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>3-20-56</u>		NAME OF CEMETERY OR CREMATORY <u>Whaley Family Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Whaleysville, Md</u>			
DATE REC'D BY LOCAL REGISTRAR <u>3-20-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	
24. FUNERAL DIRECTOR <u>Peter Whaley, Selbyville, Del.</u>		ADDRESS	

RECEIVED

MAR 22 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Hearn

3403

CERTIFICATE OF DEATH

Reg. Dist. No.

03379

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 304 Buena Vista Ave.				d. STREET ADDRESS 304 Buena Vista Ave			
3. NAME OF DECEASED (Type or print) First JOHN Middle THOMAS Last DAVIS				4. DATE OF DEATH Month MARCH Day 15 Year th 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1875		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME No Record				14. MOTHER'S MAIDEN NAME No Record			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Arra J. Davis (Wife) Address 304 Buena Vista Ave. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio-sclerotic changes of Cornary arteries DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/15/56 , 19____, to 3/15/56 , 19____, that I last saw the deceased alive on 3/15/56 , 19____, and that death occurred at 12:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) North Division St Salisbury, Maryland DATE SIGNED March 17 1956							
ACTUAL SIGNATURE Dr. Carrie I. Hearn				DATE SIGNED March 17 1956			
PHYSICIAN'S NAME (Type) Dr. Carrie I. Hearn				ADDRESS Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 19, 1956		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY *				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR MAR 19 1956	
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3404 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03380

Reg. Dist. No. 260332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 1/2</u> hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> <u>19X-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>309 Hampden Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Nathan</u> Middle <u>James</u> Last <u>Dennis</u>				4. DATE OF DEATH Month <u>March</u> Day <u>11</u> , Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>7/23/53</u>		9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Princess Anne, Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Nathan James Dennis</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Waters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Lula Dennis</u> <u>Princess Anne, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO _____ </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.H. Johnson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>March 13-56</u>			
EXAMINER'S NAME (Type) <u>R.H. Johnson M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>3/14/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley Cem.</u>			
22d. LOCATION (City, town, or county) <u>Princess Anne, Maryland</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr. Funeral Home</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>3/13/56</u>			
24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		OCCUPATION _____	
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		CAUSE OF DEATH _____	
MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		MEDICAL HISTORY _____	
PRESENT ILLNESS _____		SIGNATURE OF EXAMINER _____	
DATE OF EXAMINATION _____		TIME OF EXAMINATION _____	
PLACE OF EXAMINATION _____		SIGNATURE OF WITNESS _____	
DATE OF DEATH _____		TIME OF DEATH _____	
PLACE OF DEATH _____		SIGNATURE OF CORONER _____	

BUREAU V. S.

APR 15 1956

RECEIVED

W. H. Johnson III

W. H. Johnson III

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3405 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03381

Item 7, FilmG194 3-22-56 et.

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Delaware Ave. Ext.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Martha Middle Dixon Last Dixon		4. DATE OF DEATH Month 3 Day 5 Year 19 56	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1933
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months 3 Days 5 Hours 19 Min. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Salisbury md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Mary Benson Address Salisbury md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Edema of the brain 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute alcoholism DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH Sudden Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Earl L. Royer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 3-9-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3-10-56	
22c. NAME OF CEMETERY OR CREMATORY Green Heres		22d. LOCATION (City, town, or county) (State) Salisbury md	
23. FUNERAL DIRECTOR'S SIGNATURE Booker M. Chest		ADDRESS Salisbury md	
24a. REC'D BY REGISTRAR 3-13-56		24b. REGISTRAR'S SIGNATURE Mary W. Hollonay	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		CAUSE OF DEATH	
MANNER OF DEATH		TOXICOLOGY		LABORATORY		POSTMORTEM		HISTORICAL		FAMILY HISTORY	
SIGNATURE OF EXAMINER		DATE		TIME		LOCATION		WITNESSES		REMARKS	

RECEIVED
 MAR 15 1956
 BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03382

3406 CERTIFICATE OF DEATH

Dr. Insley

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury				TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
Pen. Gen. Hospital				200 Holland Ave			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) LEVI		(Middle) LEWIS		(Last) FIELDS		(Month) March (Day) 25 (Year) th 19 56	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	March 23, 1883	73 yrs.	Months 0	Days 2	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Shirt Factory Clerk Employee					Oxford, Maryland		U S A
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Littleton Fields				Jennie Carey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
Unk					Mrs. Annie E. Fields (Wife) 200 Holland Ave. Salisbury, Maryland		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
442X IMMEDIATE CAUSE (A) Cardio-vascular renal disease						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1941 to 3-25 , 19 56 , that I last saw the deceased alive on 3-25 , 19 56 , and that death occurred at 9: P.M. from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
Theresa Insley		M.D.		East Main St Salisbury, Maryland		Mar. 26 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Mar. 28, 1956		Wicomico Memorial Park		Salisbury, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
March 28, 1956		Mary H. Holloway		HOLLOWAY & COMPANY		* SALISBURY MARYLAND	

CERTIFICATE OF DEATH

FILE NO. 10-10-10-10

1. NAME OF DECEASED (PRINT OR TYPE)

2. SEX OF DECEASED

3. DATE OF DEATH (MONTH, DAY, YEAR)

4. TIME OF DEATH

5. PLACE OF DEATH

6. NAME OF PHYSICIAN (PRINT OR TYPE)

7. NAME OF HOSPITAL

8. NAME OF CITY

9. NAME OF TOWN OR CITY

10. NAME OF COUNTY

11. NAME OF STATE

12. NAME OF DECEASED (PRINT OR TYPE)

13. NAME OF HOSPITAL

14. NAME OF CITY

15. NAME OF TOWN OR CITY

16. NAME OF COUNTY

17. NAME OF STATE

18. NAME OF DECEASED (PRINT OR TYPE)

19. NAME OF HOSPITAL

20. NAME OF CITY

21. NAME OF TOWN OR CITY

22. NAME OF COUNTY

23. NAME OF STATE

24. NAME OF DECEASED (PRINT OR TYPE)

25. NAME OF HOSPITAL

26. NAME OF CITY

27. NAME OF TOWN OR CITY

28. NAME OF COUNTY

29. NAME OF STATE

30. NAME OF DECEASED (PRINT OR TYPE)

31. NAME OF HOSPITAL

32. NAME OF CITY

33. NAME OF TOWN OR CITY

34. NAME OF COUNTY

35. NAME OF STATE

36. NAME OF DECEASED (PRINT OR TYPE)

37. NAME OF HOSPITAL

38. NAME OF CITY

39. NAME OF TOWN OR CITY

40. NAME OF COUNTY

41. NAME OF STATE

42. NAME OF DECEASED (PRINT OR TYPE)

43. NAME OF HOSPITAL

44. NAME OF CITY

45. NAME OF TOWN OR CITY

46. NAME OF COUNTY

47. NAME OF STATE

48. NAME OF DECEASED (PRINT OR TYPE)

49. NAME OF HOSPITAL

50. NAME OF CITY

51. NAME OF TOWN OR CITY

52. NAME OF COUNTY

53. NAME OF STATE

54. NAME OF DECEASED (PRINT OR TYPE)

55. NAME OF HOSPITAL

56. NAME OF CITY

57. NAME OF TOWN OR CITY

58. NAME OF COUNTY

59. NAME OF STATE

60. NAME OF DECEASED (PRINT OR TYPE)

61. NAME OF HOSPITAL

62. NAME OF CITY

63. NAME OF TOWN OR CITY

64. NAME OF COUNTY

65. NAME OF STATE

BUREAU V. S.

MAR 20 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03383

3497

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Somerset</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		OR TOWN		OR TOWN	
TOWN <u>Salisbury</u>		<u>16½ months</u>		<u>Westover</u>		<u>19X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>Rt. 1, Box 170</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Eliza Ballard Fountain</u>				<u>March 23 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>Colored</u>	<u>Wid.</u>	<u>6/6/1867</u>	<u>88</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>--</u>		<u>USA (Maryland)</u>		<u>USA</u>	
13. FATHER'S NAME <u>Frank White</u>				14. MOTHER'S MAIDEN NAME <u>Louisa White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>Unk.</u>		<u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
<u>422.1</u> IMMEDIATE CAUSE (A)				<u>Myocardial insufficiency</u>		<u>6 days</u>	
ANTECEDENT CAUSE(S) DUE TO				<u>Arteriosclerotic cardiovascular disease</u>		<u>Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO				<u>Arteriosclerosis, general</u>		<u>Years</u>	
(C)				<u>Senility</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 10, 1954</u> , to <u>Mar. 23, 1956</u> , that I last saw the deceased alive on <u>Mar. 23, 1956</u> , and that death occurred at <u>8:35 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>E. J. Jerman</u>				ADDRESS (Street, city, town, state) <u>Deer's Head State Hosp., Salisbury, Md.</u> DATE SIGNED <u>3/24/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/27/56</u>		<u>Cottage Grove</u>		<u>Westover, Som.-Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>MAR 29 1956</u>		<u>Mary H. Holloway</u>		<u>Charles H. Ward</u>		<u>Marion Sta., Md.</u>	
						<u>Box 235</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

CITY

COUNTY

2. SEX

3. AGE

4. RACE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. DATE OF BIRTH

11. TIME OF BIRTH

12. PLACE OF DEATH

13. DATE OF DEATH

14. TIME OF DEATH

15. PLACE OF BIRTH

16. DATE OF BIRTH

17. TIME OF BIRTH

18. PLACE OF DEATH

19. DATE OF DEATH

20. TIME OF DEATH

21. PLACE OF BIRTH

22. DATE OF BIRTH

23. TIME OF BIRTH

24. PLACE OF DEATH

25. DATE OF DEATH

26. TIME OF DEATH

27. PLACE OF BIRTH

28. DATE OF BIRTH

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60. PLACE OF DEATH

61. DATE OF DEATH

62. TIME OF DEATH

63. PLACE OF BIRTH

64. DATE OF BIRTH

65. TIME OF BIRTH

66. PLACE OF DEATH

67. DATE OF DEATH

68. TIME OF DEATH

BUREAU V. S.

MAR 29 1956

RECEIVED

3/27/56 Cottage Grove

3/27/56

Charles H. Ward & Marion G. Ward

Box 12

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04539

3498 CERTIFICATE OF DEATH

Reg. Dist. No. 339

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>SOMERSET</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>1 WEEK</u>		TOWN <u>FAIRMOUNT</u>		<u>19X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Blanche</u> <u>French</u>				<u>March 30</u> <u>1957</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>White</u>		<u>WIDOWED</u>		<u>JANUARY 22, 1882</u>	
						<u>74</u> yrs.	
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
		<u>HOUSEWIFE</u>		<u>AT HOME</u>		<u>CRISFIELD, MARYLAND</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>LEVIN H. CURTIS</u>				<u>EMMA J. BERRY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>NO</u>				<u>NONE</u>		<u>MRS. DOROTHY HALL - FAIRMOUNT, MD.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>331X</u> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Myocardial Insufficiency</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pulmonary Embolus</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		19c. AUTOPSY		19d. DATE OF OPERATION	
				<u>YES</u> <input type="checkbox"/> <u>NO</u> <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/23/1957</u> , to <u>3/30/1957</u> , that I last saw the deceased alive on <u>3/30/1957</u> , and that death occurred at <u>3:43</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>David E. Sisk</u>				DATE SIGNED <u>Mar. 31/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				24. REC'D BY REGISTRAR			
				25. FUNERAL DIRECTOR'S SIGNATURE			
DATE <u>4-3-56</u>				ADDRESS <u>BRADSHAW & SONS - CRISFIELD, MD.</u>			

3508 CERTIFICATE OF DEATH

1. DEPARTMENT OF HEALTH - BALTIMORE

2. NAME OF DECEASED

3. SEX

4. AGE

5. DATE OF DEATH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF CORONER

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

15. SIGNATURE OF CLERK

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF DEPUTY SHERIFF

18. SIGNATURE OF CONSTABLE

19. SIGNATURE OF JAILER

20. SIGNATURE OF PRISONER

21. SIGNATURE OF WARDEN

22. SIGNATURE OF DEPUTY WARDEN

23. SIGNATURE OF CHIEF CLERK

24. SIGNATURE OF CHIEF DEPUTY CLERK

25. SIGNATURE OF CHIEF OF POLICE

26. SIGNATURE OF CHIEF OF FIRE DEPARTMENT

27. SIGNATURE OF CHIEF OF SANITARY DEPARTMENT

28. SIGNATURE OF CHIEF OF HEALTH DEPARTMENT

29. SIGNATURE OF CHIEF OF MENTAL DEPARTMENT

30. SIGNATURE OF CHIEF OF PHYSICIAN

BUREAU V. S.

APR 9 1956

RECEIVED

INVESTIGATION

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03384

3456 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Wicomico</u> <u>MARYLAND</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pittsville</u> LENGTH OF STAY (in this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.W.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wicomico</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pittsville</u> STREET ADDRESS (If rural give location) <u>R.F.W.</u>			
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>John</u> (Middle) <u>Gartner</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>March 27.</u> 19 <u>56.</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 15. 1901.</u>	9. AGE last birthday <u>54</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>18</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trailer Grower</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chicken Buissness</u>		11. BIRTHPLACE (State or foreign country) <u>Brooklyn, Newark, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Gartner</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Enig.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or detas of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. Charles L. Gartner (Brother)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 42202 IMMEDIATE CAUSE (A) <u>myocarditis (chronic)</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO 260X (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes mellitus</u>				18. MEDICAL CERTIFICATION <u>Pittsville, Maryland.</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>March 27 1956</u>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 1955</u> , to <u>3-27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-27</u> , 19 <u>56</u> , and that death occurred at <u>5.15 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Frank Lewis</u> M.D. <u>Willards Maryland</u> DATE SIGNED <u>3-27-56</u> ADDRESS (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 29. 56.</u>		NAME OF CEMETERY OR CREMATORY <u>Luthern Cemetery</u>		LOCATION (City, town, or county) (State) <u>Queens, New York, N.Y.</u>	
24. REC'D BY REGISTRAR DATE <u>MAR 29 1956</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway & Co. Salisbury, Maryland.</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF BURIAL OFFICIAL	

BUREAU V. S.

MAR 29 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03385

3457 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE MARYLAND		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL OR and give nearest town) Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D.# 2 (Jersey Rd)				STREET ADDRESS (If rural give location) R.D.# 2 (Jersey RD)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) MARGARET		(Middle) T		(Last) GIBBONS		(Month) (Day) (Year) March 31 st 19 56	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH July 19, 1876		9. AGE last birthday 79 yrs.	IF UNDER 1 YEAR Months 8 Days 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at own Home		11. BIRTHPLACE (State or foreign country) Highlands New Jersey		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Bartholemew McGarry				14. MOTHER'S MAIDEN NAME Elizabeth Coughlin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. Lloyd F. Gibbons (Husband) R.D.# 2 (Jersey Rd) Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) cerebral hemorrhage R.				INTERVAL BETWEEN ONSET AND DEATH 2 hours			
ANTECEDENT CAUSE(S) DUE TO (B) arteriosclerosis, generalized.				2			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) hypertension, essential, severe				5 years			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White Not white et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 52, to March 31, 19 56, that I last saw the deceased alive on March 31, 19 56, and that death occurred at 3:20 P.M. from the causes and on the date stated above.							
SIGNATURE Dr. L. V. Sohlar				DATE SIGNED April 31 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF Apr. 4th 1956		NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	
24. REC'D BY REGISTRAR APR 5 1956				REGISTRAR'S SIGNATURE Mary K. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY	
				LOCATION (City, town, or county) Salisbury, Maryland		ADDRESS SALISBURY MARYLAND	

CERTIFICATE OF DEATH

See back for instructions

1. Name of deceased (Print or write in full)

2. Date of death (Month, day, year)

3. Place of death (City, town, village, or other locality)

4. Name of physician (Print or write in full)

5. Name of hospital (Print or write in full)

6. Name of attending nurse (Print or write in full)

7. Name of coroner (Print or write in full)

8. Name of registrar (Print or write in full)

9. Name of informant (Print or write in full)

10. Name of informant (Print or write in full)

11. Name of informant (Print or write in full)

12. Name of informant (Print or write in full)

13. Name of informant (Print or write in full)

14. Name of informant (Print or write in full)

15. Name of informant (Print or write in full)

16. Name of informant (Print or write in full)

17. Name of informant (Print or write in full)

18. Name of informant (Print or write in full)

19. Name of informant (Print or write in full)

20. Name of informant (Print or write in full)

BUREAU V. 21

APR 5 1956

RECEIVED

INVESTIGATION

INVESTIGATION OF DEATHS
This section is for the use of the health department in the investigation of deaths. It contains a list of questions to be asked of the informant, and a space for the answers. The questions are designed to obtain information regarding the circumstances of the death, the health of the deceased, and the medical treatment received. The answers should be written in the space provided, and the section should be signed by the investigator.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3409 CERTIFICATE OF DEATH

03386

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Prince George's</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury, Maryland</u>		1 Yr. 5 days		TOWN <u>Hyattsville, Md.</u>		16-15-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>6800 Allison Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Robert</u>		(Middle) <u>C.</u>		(Last) <u>Godfrey</u>		(Month) <u>March</u> (Day) <u>12</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Sep.</u>	8. DATE OF BIRTH <u>Nov. 6, 1892</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Mech.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert William Godfrey</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude Meade</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420. IMMEDIATE CAUSE (A) <u>Coronary Thrombosis due to</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO <u>arterio sclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Portal Cirrhosis of Liver</u>						<u>?</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 7, 1955</u> , to <u>Mar. 12, 1956</u> , that I last saw the deceased alive on <u>Mar. 12, 1956</u> , and that death occurred at <u>6:20 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>3/12/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>3-16-56</u>		NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>WASH D.C.</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u>		ADDRESS <u>1400 Chapin</u>	
DATE <u>3/15/56</u>							

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03387

3410

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		2 weeks		TOWN <u>Baltimore</u>		3401-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
91 <u>Deer's Head State Hospital</u>				1821 <u>Eutaw Place</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>William</u> <u>Greenfeld</u>				<u>March</u> <u>21</u> 19 <u>56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>12/28/1888</u>	<u>67</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Physician</u>		<u>Physician</u>		<u>Baltimore, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Alfred Greenfeld</u>				<u>Matilda ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>				<u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) <u>Acute myocardial insufficiency</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic cardiovascular disease</u>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertensive vascular disease</u>						?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 7</u> , 19 <u>56</u> , to <u>Mar. 21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Mar. 20</u> , 19 <u>56</u> , and that death occurred at <u>4 A.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>L.V. Maldve</u>		L.V. Maldve, M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED <u>3/21/56</u>	
M.D. <u>Deer's Head Hospital, Salisbury, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 23/56</u>		NAME OF CEMETERY OR CREMATORY <u>Ohel Yakov Cong.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>March 23, 1956</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Levinson & Bros Inc</u>		ADDRESS <u>1124-26 W. North Ave</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NOTATION

1. This certificate is to be filled out by the attending physician, or in the case of a sudden death, by the coroner, or in the case of a death in custody, by the warden, or in the case of a death in a hospital, by the attending physician of the hospital. It is to be filled out in duplicate, one copy to be retained by the registrar of vital statistics, and the other copy to be sent to the county health officer. It is to be filled out in duplicate, one copy to be retained by the registrar of vital statistics, and the other copy to be sent to the county health officer.

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
MARITAL STATUS		EDUCATION		RELIGION		RACE		COLOR		CAUSE OF DEATH	
MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		SIGNATURE OF PHYSICIAN	
SIGNATURE OF CORONER		SIGNATURE OF WARDEN		SIGNATURE OF REGISTRAR		SIGNATURE OF COUNTY HEALTH OFFICER		SIGNATURE OF VICE REGISTRAR		SIGNATURE OF VICE COUNTY HEALTH OFFICER	

BUREAU V. S.

MAR 23 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3411 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03388

Reg. Dist. No.

331

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>25 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>home- Church and Bond St.</u>				d. STREET ADDRESS <u>Church and Bond St.</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Dewey</u> Last <u>Harrington</u>				4. DATE OF DEATH Month <u>3</u> Day <u>28</u> Year <u>19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-7-1898</u>		9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>28</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Frank Harrington</u>				14. MOTHER'S MAIDEN NAME <u>Dora Pritchett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>W W 1</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Benjamin Harrington, Princess Anne, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>second degree burns and asphyxiation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ Sudden						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Trapped in burning building.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>2 A.M.</u> p. m. <u>3-28-</u> 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Salisbury Wicomico Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3-29-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-30-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Vernon, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Linnian</u>				ADDRESS <u>Princess Anne, Md.</u>		24a. REC'D BY REGISTRAR <u>3-31-56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		OCCUPATION		EDUCATION		MILITARY SERVICE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1
3412 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03389

Item 9, Film 195 4-12-56 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury		c. LENGTH OF STAY IN lb 1 hr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 81 Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bertha Middle Ann Last Hastings		4. DATE OF DEATH Month 3 Day 31 Year 19 56	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1892
9. AGE (In years last birthday) 64 1/2 yrs.		10. IF UNDER 1 YEAR Months 3 Days 31 Hours 19 Min. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Salisbury		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John H. Smith		14. MOTHER'S MAIDEN NAME Ida Perdue	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Clarence T. Hastings- husband- 203 Washington	
17. INFORMANT Clarence T. Hastings- husband- 203 Washington		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 DUE TO (c) 1 hour.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Earl L. Royer		DATE SIGNED 3-31-56	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-3-56	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co. Salisbury MARYLAND		24a. REC'D BY REGISTRAR APR 4 1956	
24b. REGISTRAR'S SIGNATURE Mary A. Holloway			

AND STATE DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
 APR 4 1956
 BUREAU V. S.

Indepndt. Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completed. After the certificate is filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03390

Dr. Sohlar

3413

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 408 Ann St.				d. STREET ADDRESS 408 Ann St			
3. NAME OF DECEASED (Type or print) First GORDON Middle DENNIS Last HASTINGS				4. DATE OF DEATH Month MARCH Day 6 Year th 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1885	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 7 Days 13 Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Fredrick J. Hastings				14. MOTHER'S MAIDEN NAME Mary Frances Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Rollie Hastings (Brother) Address Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.1 Hemiplegia R. DUE TO cerebral arterial embolism L. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) auricular fibrillation DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 7h. 15min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerotic heart disease, advanced							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Salisbury, Maryland		(County) (State)	
21. I certify that I attended the deceased from March 5, 1956 , to March 6, 1956 , that I last saw the deceased alive on March 5, 1956 , and that death occurred at 7:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) 303 East St		DATE SIGNED March 7th 1956	
PHYSICIAN'S NAME (Type) Dr. L.V. Sohlar M.D.				Delmar, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 8, 1956		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE May 12 1956		May 12 1956	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3458 CERTIFICATE OF DEATH

03391

Items 8,9, FilmG194 3-23-56 et

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>Wicomico</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>MARDELA</i>		<i>14R</i>		TOWN <i>MARDELA</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>School ST</i>				STREET ADDRESS (If rural give location) <i>School ST</i>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>CHARENCE WASHINGTON HORBEMAN</i>				<i>MAR 11 1956</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>1879 MAR 16, 1880</i>	9. AGE last birthday <i>76 1/2</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>FRANKLIN HORBEMAN</i>				14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>NO</i>		16. SOCIAL SECURITY NO. <i>214-07-8908A</i>		17. INFORMANT & ADDRESS <i>MAR ELMER HORSEMAN</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
334X IMMEDIATE CAUSE (A) <i>Second attack of apoplexy</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>none</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>alone</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>none alone</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Oct 1946</i> , to <i>Mar 11, 1956</i> , that I last saw the deceased alive on <i>Mar 7, 1956</i> , and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>Be Se J. J. J.</i> ADDRESS (Street, city, town, state) <i>Mar 13, 56</i> DATE SIGNED <i>MD</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>3/13/56</i>		NAME OF CEMETERY OR CREMATORY <i>BAPTIST Church</i>		LOCATION (City, town, or county) (State) <i>MARDELA MD</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Paul J. Smith</i>		ADDRESS <i>Shaytown MD</i>	
DATE <i>MAR 16 1956</i>							

BUREAU V. S.

9551 91 844

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03392

3414 CERTIFICATE OF DEATH

Dr. Wm Smith

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>308 Truitt St</u>				STREET ADDRESS (If rural give location) <u>308 Truitt St</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>KELSO</u>		(Middle) <u>CARLTON</u>		(Last) <u>HORSEMAN</u>		(Month) (Day) (Year) <u>March 30 th 19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 28, 1887</u>	9. AGE last birthday <u>68</u> Yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>2</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee (Laborer) Adkins Lumber Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bivalve, Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George C. Horseman</u>				14. MOTHER'S MAIDEN NAME <u>Julia Wainwright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS <u>Mrs. Jennie M. Horseman (Wife) 308 Truitt St. - Salisbury, Maryland</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
241X IMMEDIATE CAUSE (A) <u>Cardiac insufficiency</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Bronchial Asthma</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>							
19a. DATE OF OPERATION <u></u>		19b. MAJOR FINDINGS OF OPERATION <u></u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u></u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u></u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u></u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>3-30</u>, 19<u>56</u>, to <u>3-30</u>, 19<u>56</u>, that I last saw the deceased alive on <u>3-30</u>, 19<u>56</u>, and that death occurred at <u>9:45P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Dr. Wm. B. Smith - Wm. B. Smith</u>				ADDRESS (Street, city, town, state) <u>M.D. Medical Center Salisbury, Maryland</u>			
DATE <u>APR 4 1956</u>				DATE SIGNED <u>4-2-1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 2, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>APR 4 1956</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY - SALISBURY MARYLAND</u>			

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3415 CERTIFICATE OF DEATH

03393

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WORCESTER</u>			
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>		<u>1 day</u>		TOWN <u>SNOW HILL</u>		<u>238-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>R.R. 1</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>MATILDA</u> <u>HUDSON</u>				<u>MARCH 6</u> <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>		<u>MARCH 10/1880</u>	<u>75-11-24</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Housewife</u>			<u>Own Home</u>		<u>Snow Hill Md</u>		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or M.K.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
<u>No</u>			<u>None</u>		<u>Mr Joseph Fisher, Snow Hill Md</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A)						<u>5 hours</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						<u>5 years</u>	
(B)							
(C)						<u>5 to 10 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED While et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>9-21</u>, 19<u>55</u>, to <u>3/5</u>, 19<u>56</u>, that I last saw the deceased alive on <u>3/5</u>, 19<u>56</u>, and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Tracy U. Dudley, M.D.</u>				<u>Berlin Md</u>		<u>3/6/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)			
<u>Cremial</u>	<u>MARCH 11/56</u>	<u>Taylor Gate</u>		<u>Snow Hill Md</u>			
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		
<u>3-9-56</u>	<u>Mary W. Holloway</u>		<u>Clay & Emma</u>		<u>Snow Hill Md</u>		

CERTIFICATE OF DEATH

Form 100-100

1. USUAL RESIDENCE (HOUSE OR BOARDING)

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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CAUSE OF DEATH

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BUREAU V. B.

MAR 12 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3416

CERTIFICATE OF DEATH

Reg. Dist. No.

03394

002

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SP. Hill. Pr. Santi.</u>		d. STREET ADDRESS <u>OCEAN ROAD.</u>	
3. NAME OF DECEASED (Type or print) <u>Sarah First Middle Last</u> <u>LIZZIE Elizabeth HUDSON</u>		4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 28 1861</u>
9. AGE (In years for birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Mumford</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Cherry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS JOHN ADKINS</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1943</u> to <u>March 16, 1956</u> , that I last saw the deceased alive on <u>March 16</u> , 19 <u>56</u> , and that death occurred at <u>6:14 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip A. Insley</u> M.D.		ADDRESS (Street, city or town, state) <u>116 E. MAIN Street Salisbury Maryland</u>	
DATE SIGNED <u>3/17/56</u>			
PHYSICIAN'S NAME (Type) <u>Philip A. Insley</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/18/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>SALISBURY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>THE HILL & JOHNSON</u> ADDRESS <u>SALISBURY, MD.</u>		24a. REC'D BY REGISTRAR <u>DATE 3-17-56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mary W. Hollaway</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1921		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT	
APRIL 4, 1968		MEMPHIS, TENNESSEE		SHOOTING		HOMICIDE		GUNSHOT WOUNDS		DR. J. H. HARRIS	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE		PREVIOUS ILLNESS		HISTORY	
CONTRACTOR		HIGH SCHOOL		METHODIST		MARRIED		NONE		NONE	
FAMILY HISTORY		SOCIAL HISTORY		HISTORICAL DATA		LABORATORY DATA		X-RAY DATA		PATHOLOGICAL DATA	
NONE		NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF MEDICAL ATTENDANT		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK	
NONE		NONE		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. S.

MAR 20 1968

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAPTER 43, SECTION 1-101, OF THE MARYLAND CODE, ANNOTATED, AND FOR THE PURPOSES OF THE FEDERAL BUREAU OF INVESTIGATION, DEPARTMENT OF JUSTICE, RECORDS ACT, 5 U.S.C. 552, AND FOR THE PURPOSES OF THE FEDERAL BUREAU OF INVESTIGATION, DEPARTMENT OF JUSTICE, RECORDS ACT, 5 U.S.C. 552, AND FOR THE PURPOSES OF THE FEDERAL BUREAU OF INVESTIGATION, DEPARTMENT OF JUSTICE, RECORDS ACT, 5 U.S.C. 552.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03395

3417 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>5 days</u>		TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>Maple Way - P.F.D. 5</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>VICKY</u> (Middle) <u>LYNN</u> (Last) <u>INSCOE</u>				(Month) <u>MARCH</u> (Day) <u>25</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>June 18, 1955</u>	<u>9 Months</u>	<u>9</u>	<u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<u>Infant</u>		<u>Infant</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Bobby INSCOE</u>				<u>JUNE ELIZABETH BORTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>NONE</u>		<u>Mr. Bobby INSCOE, SAME</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>340.1</u> IMMEDIATE CAUSE (A) <u>Meningitis, Acute - ? Pneumococci</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 22</u>, 19<u>56</u>, to <u>Mar 25</u>, 19<u>56</u>, that I last saw the deceased alive on <u>Mar 25</u>, 19<u>56</u>, and that death occurred at <u>8:55</u> A.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>Morris C. Lambelin</u>		<u>M.D. 707 Camden Ave Salisbury Md</u>		<u>3/25/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3/27/1956</u>		<u>WICOMICO MEMORIAL PARK</u>		<u>SALISBURY, MARYLAND</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>3-26-56</u>		<u>Mary W. Holloman</u>		<u>Hill & Johnson Co. SALISBURY, Md.</u>		<u>Holloman & Baker</u>	

2082171436

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CITY CERTIFICATE OF DEATH

REG. DIST. NO.

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE

4. RACE

5. BIRTH DATE

6. BIRTH PLACE

7. MARRIAGE DATE

8. MARRIAGE PLACE

9. OCCUPATION

10. CAUSE OF DEATH

11. PLACE OF DEATH

12. TIME OF DEATH

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESS

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF CORONER

17. SIGNATURE OF MINISTER

18. SIGNATURE OF CLERGYMAN

19. SIGNATURE OF CHURCH

20. SIGNATURE OF BURIAL

21. SIGNATURE OF INTERMENT

22. SIGNATURE OF CREMATION

23. SIGNATURE OF OTHER

24. SIGNATURE OF DECEASED

25. SIGNATURE OF WITNESS

26. SIGNATURE OF PHYSICIAN

27. SIGNATURE OF CORONER

28. SIGNATURE OF MINISTER

29. SIGNATURE OF CLERGYMAN

30. SIGNATURE OF CHURCH

31. SIGNATURE OF BURIAL

32. SIGNATURE OF INTERMENT

33. SIGNATURE OF CREMATION

34. SIGNATURE OF OTHER

35. SIGNATURE OF DECEASED

36. SIGNATURE OF WITNESS

37. SIGNATURE OF PHYSICIAN

38. SIGNATURE OF CORONER

39. SIGNATURE OF MINISTER

40. SIGNATURE OF CLERGYMAN

41. SIGNATURE OF CHURCH

42. SIGNATURE OF BURIAL

43. SIGNATURE OF INTERMENT

44. SIGNATURE OF CREMATION

45. SIGNATURE OF OTHER

BUREAU V. S.

MAR 20 1956

RECEIVED

INSTRUCTIONS

1. This certificate is to be filled out by the physician or coroner who has examined the body of the deceased. It is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland. 2. The name of the deceased should be written in full, including the middle name if there is one. 3. The sex should be written as male or female. 4. The age should be written in years, months, and days. 5. The race should be written as white, negro, or other. 6. The birth date should be written in full, including the month and day. 7. The birth place should be written in full, including the state or country. 8. The marriage date should be written in full, including the month and day. 9. The marriage place should be written in full, including the state or country. 10. The occupation should be written in full. 11. The cause of death should be written in full, including the immediate and remote causes. 12. The place of death should be written in full, including the street, city, and state. 13. The time of death should be written in full, including the hour, minute, and second. 14. The signature of the deceased should be written in full. 15. The signature of the witness should be written in full. 16. The signature of the physician should be written in full. 17. The signature of the coroner should be written in full. 18. The signature of the minister should be written in full. 19. The signature of the clergyman should be written in full. 20. The signature of the church should be written in full. 21. The signature of the burial should be written in full. 22. The signature of the interment should be written in full. 23. The signature of the cremation should be written in full. 24. The signature of other should be written in full. 25. The signature of the deceased should be written in full. 26. The signature of the witness should be written in full. 27. The signature of the physician should be written in full. 28. The signature of the coroner should be written in full. 29. The signature of the minister should be written in full. 30. The signature of the clergyman should be written in full. 31. The signature of the church should be written in full. 32. The signature of the burial should be written in full. 33. The signature of the interment should be written in full. 34. The signature of the cremation should be written in full. 35. The signature of other should be written in full.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3418

CERTIFICATE OF DEATH

03396

Reg. Dist. No. 332

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town)			
TOWN <u>12 SALISBURY</u>		<u>3 days</u>		TOWN <u>QUANTICO</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>R.R. #1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>IRA</u>		(Middle) <u>LINWOOD</u>		(Last) <u>JONES</u>		(Month) (Day) (Year)	
						<u>MARCH 27 1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR IF UNDER 24 HRS.		
<u>MALE</u>	<u>COLORED</u>		<u>7-31-1903</u>	<u>52 yrs.</u>	Months <u>7</u>	Days <u>16</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>AUTO MECHANIC</u>		<u>GARAGE</u>		<u>HORLOCK DORCHESTER Co., MD.</u>		<u>U. S. A.</u>	
13. FATHER'S NAME <u>NOAH JONES</u>				14. MOTHER'S MAIDEN NAME <u>HATTIE MCGLOTTEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>NO</u>		<u>220-10-8060</u> <u>MRS. LAUNIA A. JONES, QUANTICO MD RT. #1</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
416X IMMEDIATE CAUSE (A) <u>Edema and Congestive Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Rheumatic Heart Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>MARCH 19, 1956</u> , to <u>MARCH 27, 1956</u> , that I last saw the deceased alive on <u>MARCH 26, 1956</u> , and that death occurred at <u>1:20 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Herbert Sembley</u> M.D. <u>Salisbury Md</u>				DATE SIGNED <u>3/27/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>BURIAL</u>		<u>4-1-56</u>		<u>ODD FELLOWS CEMETERY</u>		<u>WITFORD WICOMICO MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>APR 2 1956</u>		<u>Mary H. Holloway</u>		<u>J.F. STEWART FUNERAL HOME</u>		<u>Salisbury, MD</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

5. DATE OF BIRTH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

BUREAU V. S.

APR 2 1956

RECEIVED

PRODUCTION

This is a form for the registration of deaths in Maryland. It is to be filled out by the physician or other person who has attended the deceased, or by the coroner or other person who has examined the body. The form is to be filed with the local health officer, who will forward it to the State Department of Health. The form is to be filled out in duplicate, one copy to be filed with the local health officer and the other copy to be filed with the State Department of Health. The form is to be filled out in duplicate, one copy to be filed with the local health officer and the other copy to be filed with the State Department of Health. The form is to be filled out in duplicate, one copy to be filed with the local health officer and the other copy to be filed with the State Department of Health.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03397

Dr. Insley

3419

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Private Sanitarium		d. STREET ADDRESS 309 Middle Blvd.	
3. NAME OF DECEASED (Type or print) First LOUISE Middle ELIZABETH Last JONES		4. DATE OF DEATH Month MARCH Day 2nd Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUN 24, 1875
9. AGE (In years last birthday) 80		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David J. Gore		14. MOTHER'S MAIDEN NAME Alexine La Rue	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Charles J. Potts (Atty)		Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma breast DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1941	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1941 , to March 2, 1956 , that I last saw the deceased alive on Feb 21, 1956 , and that death occurred at 2:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip Insley M.D.		ADDRESS (Street, city or town, state) East Main St DATE SIGNED March 4 1956	
PHYSICIAN'S NAME (Type) Dr. Philip Insley - M.D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 4, 1956	
22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR Mar. 6, 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
MARRIED		CAUSE OF DEATH	
DISEASE		MANNER OF DEATH	
SIGNED BY		DATE	
PLACE		COUNTY	
STATE		FEDERAL BUREAU OF INVESTIGATION	
U.S. DEPARTMENT OF JUSTICE		WASHINGTON, D.C.	

BUREAU V. S.

MAR 6 1956

RECEIVED

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
MARRIED		CAUSE OF DEATH	
DISEASE		MANNER OF DEATH	
SIGNED BY		DATE	
PLACE		COUNTY	
STATE		FEDERAL BUREAU OF INVESTIGATION	
U.S. DEPARTMENT OF JUSTICE		WASHINGTON, D.C.	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 2, Film 197 5-23-56 et

03398

3420

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Somerset</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>		LENGTH OF STAY (in this place) <u>1 WA</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR James Quarter</u>		<u>19X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>PALESBURY</u>			
3. NAME OF DECEASED (Type or Print) <u>Mary</u> (First) <u>W. A.</u> (Middle) <u>James.</u> (Last)				4. DATE OF DEATH (Month) <u>MARCH</u> (Day) <u>5</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1886</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>James Quarter</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Arthur Roberts</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> If Yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>219-07-7808</u>		17. INFORMANT & ADDRESS <u>Margaret Jackson</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>002X Acute tuberculous pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Tuberculosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/27</u> , 19 <u>56</u> , to <u>3/5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/5</u> , 19 <u>56</u> , and that death occurred at <u>8 A</u> .M, from the causes and on the date stated above.							
SIGNATURE <u>Margaret Jackson</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Md</u>		DATE SIGNED <u>3/6/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3/8/56</u>		NAME OF CEMETERY OR CREMATORY <u>James Quarter Cem</u>		LOCATION (City, town, or county) (State) <u>James Quarter Md</u>	
24. REC'D BY REGISTRAR DATE <u>3-12-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Brooklyn West</u> ADDRESS			

MAR 14 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03399

CERTIFICATE OF DEATH

3421

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>VIRGINIA</u> COUNTY <u>Accomac</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Temperanceville 83x.3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Justice</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 11 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>March 11, 1936</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Milton Justice</u>				14. MOTHER'S MAIDEN NAME <u>Della Mills</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Milton Justice</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
776X IMMEDIATE CAUSE (A) <u>Pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-11</u> , 19 <u>56</u> , to <u>3-11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-11</u> , 19 <u>56</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. Morris A. Lambdin</u>				ADDRESS (Street, city, town, state) <u>707 Camden Ave, Salisbury, Md.</u>			
DATE THEREOF <u>3-12-56</u>				DATE SIGNED <u>3/12/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
		<u>Peninsula General Hospital</u>		<u>Salisbury, Wicomico</u>		<u>md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>3-12-56</u>		<u>Mary W. Holloway</u>		<u>Peninsula General Hospital</u>			

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INSTRUCTIONS
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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3422

CERTIFICATE OF DEATH

03400

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		Since <u>3/3/56</u>		TOWN <u>Snow Hill</u>		<u>23X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS (If rural give location) <u>RFD #2</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Claude</u> <u>Ralston</u> <u>Kennedy</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3</u> <u>7</u> <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 28, 1924</u>	9. AGE last birthday <u>31</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Porterville, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Isaac Madison Kennedy</u>				14. MOTHER'S MAIDEN NAME <u>Bernice Ralston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>196-16-7061</u>		17. INFORMANT & ADDRESS <u>Patient when admitted</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>002X</u> IMMEDIATE CAUSE (A) <u>For adv pulm Tuberculosis</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) (C)				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>since 1943</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/3</u> , 19 <u>56</u> , to <u>3/7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/6</u> , 19 <u>56</u> , and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>S. H. Under</u> ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>3/7/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 13, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Porterville, Pa.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>3-9-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Hollonay</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Brown</u>		ADDRESS <u>Salisbury, Md.</u>	

CERTIFICATE OF DEATH

1. DECEASED'S NAME (Last, first, middle initial)

2. SEX

3. AGE

4. PLACE OF BIRTH

5. DATE OF BIRTH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF NEXT OF KIN

14. SIGNATURE OF CLERK

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CORONER

18. SIGNATURE OF DISTRICT ATTORNEY

19. SIGNATURE OF COUNTY CLERK

20. SIGNATURE OF TOWNSHIP CLERK

21. SIGNATURE OF VILLAGE CLERK

22. SIGNATURE OF CITY CLERK

23. SIGNATURE OF STATE CLERK

24. SIGNATURE OF NATIONAL CLERK

25. SIGNATURE OF INTERNATIONAL CLERK

26. SIGNATURE OF UNITED NATIONS CLERK

27. SIGNATURE OF WORLD CLERK

28. SIGNATURE OF COSMOS CLERK

29. SIGNATURE OF UNIVERSE CLERK

BUREAU V. 1

MAR 12 1956

RECEIVED

[Handwritten signatures and notes]

UNREGISTERED

RECEIVED BY THE REGISTRAR OF DEATHS, BALTIMORE, MD. MAR 12 1956

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INSTRUCTIONS

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VS AISC 7-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03401

3423

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>23 hrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>R.F.D.#2</u>			
3. NAME OF DECEASED (Type or Print) <u>BABY GIRL</u> (First) <u>KING</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>march</u> (Day) <u>23</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Newborn</u>	8. DATE OF BIRTH <u>MARCH 22, 1956</u>	9. AGE last birthday <u>—</u> yrs.	IF UNDER 1 YEAR Months <u>23</u> Days <u>20</u>		IF UNDER 24 HRS. Hours <u>23</u> Min. <u>20</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>infant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Alvin King</u>				14. MOTHER'S MAIDEN NAME <u>JANE CATHERINE MILLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Mr. W.A. King, SAME</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
162.5 IMMEDIATE CAUSE (A) <u>PREMATURE IT</u>						INTERVAL BETWEEN ONSET AND DEATH <u>23 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>DU TO</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>1 DISEASE</u>						<u>23 hrs</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 21, 1956</u> , to <u>March 23, 1956</u> , that I last saw the deceased alive on <u>March 22, 1956</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert H. Lunderson</u>				ADDRESS (Street, city, town, state) <u>716 1/2 Division St Salisbury</u>		DATE SIGNED <u>3/25/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>cremation</u>				DATE THEREOF <u>3/24/56</u>		NAME OF CEMETERY OR CREMATORY <u>J. W. LEES & SON</u>	
24. REC'D BY REGISTRAR <u>3-24-56</u>				REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury</u>	
DATE				ADDRESS		STATE	
<u>2082251351</u>				<u>Franklin B. Hill Jr.</u>		<u>D.C.</u>	

CERTIFICATE OF DEATH

3-58

1. NAME (PRINT OR TYPE)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. DATE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF FUNERAL HOME

16. SIGNATURE OF BURIAL PLACE

17. SIGNATURE OF INTERVIEWER

18. SIGNATURE OF OFFICIAL

19. SIGNATURE OF CLERK

20. SIGNATURE OF ASSISTANT

21. SIGNATURE OF CHIEF

22. SIGNATURE OF DEPUTY

23. SIGNATURE OF SECRETARY

24. SIGNATURE OF ASSISTANT SECRETARY

25. SIGNATURE OF CLERK

26. SIGNATURE OF ASSISTANT CLERK

27. SIGNATURE OF CHIEF CLERK

28. SIGNATURE OF DEPUTY CHIEF CLERK

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34. SIGNATURE OF DEPUTY CHIEF CLERK

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225. SIGNATURE OF CHIEF CLERK

226. SIGNATURE OF DEPUTY CHIEF CLERK

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239. SIGNATURE OF SECRETARY

240. SIGNATURE OF ASSISTANT SECRETARY

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243. SIGNATURE OF CHIEF CLERK

244. SIGNATURE OF DEPUTY CHIEF CLERK

245. SIGNATURE OF SECRETARY

246. SIGNATURE OF ASSISTANT SECRETARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3424

CERTIFICATE OF DEATH

03402

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <i>Winnebago</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i> c. LENGTH OF STAY IN 1b <i>Life</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Winnebago</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mardella</i> d. STREET ADDRESS <i>Rural</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Drene</i> First <i>Lamb</i> Middle <i>Lamb</i> Last		4. DATE OF DEATH Month <i>3</i> Day <i>20</i> Year <i>1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-30-04</i>	9. AGE (In years last birthday) <i>51</i> yrs.	IF UNDER 1 YEAR Months <i>3</i> Days <i>20</i> Hours <i>19</i> Min. <i>56</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Mardella</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Bern Jones</i>		14. MOTHER'S MAIDEN NAME <i>Martha Boskells</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>215-14-3714</i>		17. INFORMANT <i>Lillie Boskells</i> Address <i>Mardella</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myelogenous Leukemia</i> <i>2041</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Unknown</i> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <i>6 months?</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. <i>11</i> p. m. <i>19</i>		20d. INJURY OCCURRED While _____ Not while _____ at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Salisbury</i>	
20f. (City or town) <i>Winnebago</i> (County) <i>md</i> (State) <i>md</i>					
21. I certify that I attended the deceased from <i>Mar 10, 1956</i> , to <i>Mar 20, 1956</i> that I last saw the deceased alive on <i>Mar 19, 1956</i> , and that death occurred at <i>3:25 P.M.</i> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>G. Herbert Semblly</i> M.D.		ADDRESS (Street, city or town, state) <i>400 E. Church St. Salisbury Md</i>		DATE SIGNED <i>3/21/56</i>	
PHYSICIAN'S NAME (Type) <i>G. Herbert Semblly</i>		ADDRESS <i>Salisbury Winnebago Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/25/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Green House Mm Cmn</i>		22d. LOCATION (city, town, or county) <i>Salisbury md</i> (State) <i>md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pecker Miller</i>		ADDRESS _____		24a. REC'D BY REGISTRAR <i>3-27-56</i> 24b. REGISTRAR'S SIGNATURE <i>Mary W. Holloman</i>	

BUREAU V. S.

MAR 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Mitchell

3425

CERTIFICATE OF DEATH

Reg. Dist. No.

03403

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Private Sanitarium		d. STREET ADDRESS No Street Address	
3. NAME OF DECEASED (Type or print) BERTHA LANG		4. DATE OF DEATH March 2nd 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at Home	9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR 11 Months 18 Days IF UNDER 24 HRS. 19 Hours 56 Min.
11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Saunders Blades		14. MOTHER'S MAIDEN NAME Arintha Davis (more)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Frank W. Coulbourn (Daughter) Address 106 Fook St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 8 , 19 53 , to 3/2 , 19 56 , that I last saw the deceased alive on 3/2 , 19 56 , and that death occurred at 8:45 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE A. C. Mitchell M.D.		ADDRESS (Street, city or town, state) Maryland Ave. DATE SIGNED March 5 1956	
PHYSICIAN'S NAME (Type) Dr. Andrew Mitchell M.D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 5, 1956	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR MAR 7 1956	24b. REGISTRAR'S SIGNATURE Mary H. Holloways

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	
JAMES EARL RAY		Male		35		1928		Missouri		April 4, 1968		Memphis, Tennessee		Gunshot wound		Suicide		[Signature]		[Signature]		[Signature]	
13. Occupation		14. Education		15. Marital status		16. Date of marriage		17. Name of spouse		18. Name of father		19. Name of mother		20. Name of informant		21. Name of registrar		22. Name of physician		23. Name of hospital		24. Name of funeral home	
Attorney		High School		Married		1950		Maryland		Missouri		Missouri		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray	
25. Date of funeral		26. Place of funeral		27. Name of funeral home		28. Name of cemetery		29. Name of burial place		30. Name of burial place		31. Name of burial place		32. Name of burial place		33. Name of burial place		34. Name of burial place		35. Name of burial place		36. Name of burial place	
April 10, 1968		Memphis, Tennessee		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray	

BUREAU V. 5

MAR 7 1968

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSES.

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3426 CERTIFICATE OF DEATH

03404

Item 9, FilmG194 3-27-56 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>12</u> TOWN <u>Salisbury</u>		<u>5 yrs.</u>		TOWN <u>Chestertown</u> <u>14372</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Louise</u> <u>Lawrence</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 15</u> <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>?</u>	9. AGE last birthday <u>Approx. 90</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Myocardial insufficiency</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>				<u>?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerosis, General</u>				<u>?</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 5</u> , 19 <u>51</u> , to <u>Mar. 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Mar. 15</u> , 19 <u>56</u> , and that death occurred at <u>12:50 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>R. J. Gore, M.D.</u>				ADDRESS (Street, city, town, state) <u>Deer's Head State Hospital; Salisbury, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Interred</u>				DATE THEREOF <u>3/20/56</u>		NAME OF CEMETERY OR CREMATORY <u>Univ. of Md. Med. School</u>	
24. REC'D BY REGISTRAR <u>Mary H. Holloway</u>				25. FUNERAL DIRECTOR'S SIGNATURE		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE <u>MAR 22 1956</u>							

BUREAU V. S.

MAR 22 1956

RECEIVED

3427

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03405

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worc.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>12 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> <u>23x 2 ✓</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Lawson</u> Last <u>—</u>				4. DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>—</u>		9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>880.9 Acute methyl alcohol poisoning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>—</u> o. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Embalmed</u>		<u>3/20/56</u>		<u>Univ. of Md. Med. Schol</u>		<u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>—</u>				<u>—</u>		<u>—</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing it "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 22 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03406

3428

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>4 yrs.</u>		TOWN <u>Woodbine</u>		<u>13X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>Florence Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Randolph</u>		(Middle) <u>D.</u>		(Last) <u>Layton</u>		<u>March 7 1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>3/2/1853</u>	<u>103</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>-</u>		<u>NONE</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>?</u>				<u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>-</u>		<u>NONE</u>		<u>Hospital records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>332X</u> IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, general and cerebral</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Senility</u>						<u>?</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>-</u>		<u>-</u>		<u>-</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>-</u>		<u>-</u>		<u>-</u>			
22. I hereby certify that I attended the deceased from <u>Nov. 6</u>, 19<u>51</u>, to <u>Mar. 7</u>, 19<u>56</u>, that I last saw the deceased alive on <u>Mar. 7</u>, 19<u>56</u>, and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Dr. V. Juerman</u>		<u>Mar 10 1956</u>		<u>Stonington Chapel</u>		<u>Howard Co Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>BURIAL</u>		<u>Mary H. Holloway</u>		<u>Raymond E. Zorber, Laytonville Ind.</u>			
DATE		DATE		DATE		DATE	
<u>MAR 12 1956</u>		<u>MAR 12 1956</u>		<u>MAR 12 1956</u>		<u>MAR 12 1956</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

MAR 12 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03407

3429

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>WORCESTER</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
12 TOWN <u>SALISBURY MARYLAND</u>		2 WEEKS		STOCKTON		23X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
PENINSULA GENERAL Hospital							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last)							
HOMER L. MASON, SR.				MARCH 16 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	White	MARRIED	May 7, 1882	73	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Merchant		General Store		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George L. Mason				Margaret L. Dickerson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		HOMER L. MASON Jr. Stockton, Md			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				177X IMMEDIATE CAUSE (A)			
				carcinoma of prostate			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-2</u> , 19 <u>56</u> , to <u>3-16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-2</u> , 19 <u>56</u> , and that death occurred at <u>1:25 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
WELLEN R. ELIAS, JR. M.D.				SALISBURY, Md.		3-16-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
BURIAL	3-18-56	GUNBY PRESBYTERIAN		STOCKTON, Md			
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		
	Mary H. Holloway		Henry H. Watson		POCONOKE, Md		

MAR 20 1956

CERTIFICATE OF DEATH

1956

Reg. Dist. No.

1. UNDER SIGNATURE OF PHYSICIAN OR DECLARED

2. PLACE OF DEATH

3. NAME OF DECEASED
4. SEX
5. AGE
6. DATE OF BIRTH
7. PLACE OF BIRTH
8. OCCUPATION
9. MARITAL STATUS
10. RACE
11. COLOR
12. RELIGION
13. EDUCATION
14. SOCIAL SECURITY NUMBER
15. MOTHER'S MAIDEN NAME
16. FATHER'S NAME
17. DATE OF DEATH
18. TIME OF DEATH
19. CAUSE OF DEATH
20. MANNER OF DEATH
21. PLACE OF INTERMENT
22. NAME OF INTERMENT PLACE
23. DATE OF INTERMENT
24. SIGNATURE OF REGISTRAR
25. DATE OF REGISTRATION

NOTATION

BUREAU V. S.
V. S.

1956

MAR 20 1956

RECEIVED

3430

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH o. COUNTY <u>Pocomoke</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Delaware</u> b. COUNTY <u>Dussess</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seelbyville 46X-3</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springhill Sanatorium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Caleb Layton McCabe</u> First Middle Last				4. DATE OF DEATH <u>Mar. 23</u> 19 <u>56</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1865</u> 91 yrs.	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant and Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Seelbyville Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elisha McCabe</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Murray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Brice E. McCabe</u> Address <u>Seelbyville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular renal disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-8</u> 19 <u>56</u> , to <u>3-23</u> 19 <u>56</u> , that I last saw the deceased alive on <u>3-23</u> 19 <u>56</u> , and that death occurred at <u>2 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Phleg A. Luby</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Md</u>		DATE SIGNED <u>3-25-56</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/26/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Red Men's</u>		22d. LOCATION (City, town, or county) (State) <u>Seelbyville Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas H. Watson</u>				ADDRESS <u>Pocomoke Md.</u>		24a. REC'D BY REGISTRAR <u>Mar. 28, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and the funeral director must sign the certificate. After the funeral director has signed the certificate, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 28 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03409

3431

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Somerset			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury		2 days		TOWN Manokin		19x-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Mary Brown McLane				March 29 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)		
Female	White	Married	12/20/1890	65 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Housework		Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph L. Brown				Annie L. Long			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Unk.				Hospital Records			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
153X							
IMMEDIATE CAUSE (A)						?	
Generalized carcinomatosis							
ANTECEDENT CAUSE(S) DUE TO						4 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Mar. 27, 1956 , to Mar. 29, 1956 , that I last saw the deceased alive on Mar. 28, 1956 , and that death occurred at 5:27 A.M. from the causes and on the date stated above.							
SIGNATURE		L.V. Maldve, M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
		M.D. Deer's Head Hospital, Salisbury, Md.				3/29/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		3-31-56		Manokin Pres. Cem. Prince Georges Co. Md.			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 4-2-56		Maryd. Holloray		Lewis B. Watson Prince Georges Co. Md.			

CERTIFICATE OF DEATH

<p>NAME OF DECEASED [Faint text]</p>		<p>AGE [Faint text]</p>		<p>SEX [Faint text]</p>		<p>DATE OF DEATH [Faint text]</p>	
<p>PLACE OF DEATH [Faint text]</p>		<p>CAUSE OF DEATH [Faint text]</p>		<p>MANNER OF DEATH [Faint text]</p>		<p>DATE OF BIRTH [Faint text]</p>	
<p>EDUCATION [Faint text]</p>		<p>OCCUPATION [Faint text]</p>		<p>RELIGION [Faint text]</p>		<p>DATE OF MARRIAGE [Faint text]</p>	
<p>PREVIOUS ILLNESS [Faint text]</p>		<p>PREVIOUS SURGERY [Faint text]</p>		<p>PREVIOUS TRAUMA [Faint text]</p>		<p>PREVIOUS DRUGS [Faint text]</p>	
<p>DATE OF EXAMINATION [Faint text]</p>		<p>PLACE OF EXAMINATION [Faint text]</p>		<p>NAME OF PHYSICIAN [Faint text]</p>		<p>NAME OF REGISTRAR [Faint text]</p>	
<p>SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>SIGNATURE OF REGISTRAR [Faint text]</p>		<p>DATE OF SIGNATURE [Faint text]</p>		<p>PLACE OF SIGNATURE [Faint text]</p>	

MADE

BUREAU V. S.

MAR 10 1956

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH

MASSACHUSETTS DEPARTMENT OF HEALTH
 BOSTON, MASSACHUSETTS
 02111

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing it and "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

3432

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03411

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN lb <u>5 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
3. NAME OF DECEASED (Type or print) First <u>Harriet</u> Middle <u>Ford</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>3-</u> Day <u>27</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 31, 1884</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>12</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>12</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Ford</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. John L. Bond, 308 Beckford Ave., Salisbury, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lysol poisoning</u> 971.4 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>---</u> DUE TO (c) <u>---</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Patient drank Lysol on 3-22-56</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient drank Lysol on 3-22-56</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>3-22 19 56</u> p. m. <u>---</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>
20f. (City or town) <u>Salisbury</u>		20g. (County) <u>Wicomico</u>	
20h. (State) <u>Md.</u>		20i. (City or town) <u>Salisbury</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3-27-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/29/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Still Pond Cemetery</u>	22d. LOCATION (City, town, or county) <u>Still Pond, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hill & Johnson Co. Salisbury, Maryland</u>		24a. REC'D BY REGISTRAR <u>Norman T. Baker</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		DATE <u>3-28-56</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		Jan 15, 1956		Home	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Catholic	
Signature of Examiner		Signature of Coroner		Signature of Physician		Signature of Family		Signature of Witness	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Examination		Time of Examination		Place of Examination		Signature of Examiner		Signature of Coroner	
Jan 15, 1956		10:00 AM		Home		[Signature]		[Signature]	

RECEIVED
APR 2 1956
BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3433 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03412

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>42 days</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City - Rural</u> d. STREET ADDRESS <u>R2D #3</u>																	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Earl</u> Last <u>Overholt</u>				4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1956</u>																	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 18 - 1951</u>		9. AGE (In years last birthday) <u>4</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.				
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>													
13. FATHER'S NAME <u>Charles Overholt</u>				14. MOTHER'S MAIDEN NAME <u>Sue Jones</u>																	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Charles Overholt</u> Address <u>Pocomoke City, Md.</u>																	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia as shown by autopsy</u> 917.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Accidental Burns</u> DUE TO (c) <u>Self-inflicted</u>								INTERVAL BETWEEN ONSET AND DEATH <u>13</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Plugging in an electric plug into a socket as heat to clothes</u>																	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a.m. <u>June 6</u> 19 <u>56</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) <u>Home</u>		20f. City or town (County) (State) <u>Worcester Md</u>													
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Self-inflicted <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																					
ACTUAL SIGNATURE <u>N.E. Sartorius Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																	
EXAMINER'S NAME (Type) <u>Norman E. Sartorius</u>				DATE SIGNED <u>3/8/56</u>																	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/11/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke Md.</u>															
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert Watson</u>				ADDRESS <u>Pocomoke, Md.</u>		24a. REC'D BY REGISTRAR <u>Mary H. Holloway</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>													

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 13 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03413

3434

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico Kent</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>Since 2/15/56</u>		TOWN <u>Rock Hall</u>		<u>14X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS (if rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>George Maurice Pearce</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 3 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Oct. 20, 1896</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chesapeake Bay</u>		11. BIRTHPLACE (State or foreign country) <u>Rock Hall, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wesley Pearce</u>				14. MOTHER'S MAIDEN NAME <u>Julia Goodman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Patient when admitted to hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Chronic nephritis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic myocarditis</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/15, 1956</u> , to <u>3/3/56</u> , that I last saw the deceased alive on <u>3/3/56</u> , 19 <u>56</u> , and that death occurred at <u>8:20 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>S. H. Burkle</u> M.D.				DATE SIGNED <u>3/3/56</u> (State)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar. 6, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Cem.</u>		LOCATION (City, town, or county) <u>Rock Hall, Md.</u>	
24. REC'D BY REGISTRAR <u>3-6-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>		ADDRESS <u>Chestertown, M</u>	

CERTIFICATE OF DEATH

3133

1. NAME OF DECEASED JAMES M. JONES		2. PLACE OF DEATH BALTIMORE, MARYLAND	
3. SEX Male		4. AGE 35	
5. OCCUPATION Salesman		6. CAUSE OF DEATH Heart Disease	
7. DATE OF DEATH March 8, 1956		8. TIME OF DEATH 10:30 AM	
9. PLACE OF BIRTH Baltimore, Maryland		10. DATE OF BIRTH March 15, 1921	
11. NAME OF PHYSICIAN Dr. J. M. Jones		12. NAME OF FUNERAL HOME J. M. Jones & Co.	
13. NAME OF NEXT OF KIN Mrs. J. M. Jones		14. ADDRESS OF NEXT OF KIN 1234 Main St., Baltimore, Md.	
15. NAME OF MINISTER OF RELIGION Rev. J. M. Jones		16. NAME OF CHURCH St. John's Episcopal Church	
17. NAME OF BURIAL PLACE Greenwood Cemetery		18. NAME OF BURIAL PLACE Greenwood Cemetery	
19. NAME OF BURIAL PLACE Greenwood Cemetery		20. NAME OF BURIAL PLACE Greenwood Cemetery	

INSTRUCTIONS

This certificate is to be filled out by the physician or the funeral director. It is to be filed in the office of the Registrar of the State Department of Health. The certificate is to be filled out in duplicate. One copy is to be filed in the office of the Registrar and the other copy is to be filed in the office of the funeral director. The certificate is to be filled out in duplicate. One copy is to be filed in the office of the Registrar and the other copy is to be filed in the office of the funeral director.

BUREAU V. 3

MAR 8 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital. Attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03414

Dr. Gilmore & Ellis

3435

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS 700 East Church St	
3. NAME OF DECEASED (Type or print) First HANNAH Middle ELIZABETH Last POLLITT		4. DATE OF DEATH Month MARCH Day 9 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1884
9. AGE (In years last birthday) yrs. 71		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at own home	
11. BIRTHPLACE (State or foreign country) Delmar, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joshua D. Parker		14. MOTHER'S MAIDEN NAME Mary Emily Riley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Creston A. Pollitt (Husband)		Address 700 E. Church St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 48 hrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-7 , 19 56 , to 3-9 , 19 56 that I last saw the deceased alive on 3-9 , 19 56 , and that death occurred at 9:25 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Medical Center March 10 1956			
ACTUAL SIGNATURE Wilber R. Ellis Jr. M.D.		PHYSICIAN'S NAME (Type) Dr. David J. Gilmore M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 11, 1956	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park
22d. LOCATION (City, town, or county) (State) Salisbury, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY	
24a. REC'D BY REGISTRAR MAR 12 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

BUREAU V. 5

MAR 12 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3436 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03415

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Washington</u>	
3. NAME OF DECEASED (Type or print) <u>First</u> <u>Defted</u> <u>Middle</u> <u>Prutt</u> <u>Last</u>		4. DATE OF DEATH <u>Month</u> <u>3</u> <u>Day</u> <u>9</u> <u>Year</u> <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 16 - 1885</u> 70 yrs.
9. AGE (In years last birthday) <u>70</u>		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Collector</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Prutt</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. Parsons</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>315-16-3538</u>	
17. INFORMANT <u>Jack Prutt</u>		Address <u>Berlin Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>825X</u> <u>Undetermined</u> DUE TO <u>Left Sides Cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Due to</u> <u>Arteriosclerosis from auto accident</u> (c) <u>Arteriosclerosis from auto accident</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pressed against the hood in auto collision</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile Collision</u>	
20c. TIME OF INJURY <u>2-21-56</u> Month, Day, Year	20d. INJURY OCCURRED <u>While at work</u> <input checked="" type="checkbox"/> <u>Not while at work</u> <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) <u>Berlin-Worcester</u> (County) <u>Md.</u> (State)
21. I certify that I took charge of the remains described above, held or Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. H. Smith</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. H. Smith</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/12/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS</u>
		22d. LOCATION (City, town, or county) <u>BERLIN</u>	(State) <u>MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burby</u>		ADDRESS <u>Berlin Md</u>	
24a. REC'D BY REGISTRAR <u>DATE 3/13-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

BUREAU V. S.

MAR 15 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3437

CERTIFICATE OF DEATH

03416

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>4 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Greensboro</u>		<u>05X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Maude</u> <u>E.</u> <u>Reid</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Mar.</u> <u>22</u> <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11/12/1879</u>		9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Kelley</u>				14. MOTHER'S MAIDEN NAME <u>Esther Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
191X IMMEDIATE CAUSE (A) <u>Cachexia</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Squamous cell Carcinoma of face with local metastasis</u>						<u>15 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>-</u>		19b. MAJOR FINDINGS OF OPERATION <u>-</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>-</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21f. HOW DID INJURY OCCUR? <u>-</u>			
22. I hereby certify that I attended the deceased from <u>1/23</u> , 19 <u>52</u> , to <u>3/22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Mar. 21</u> , 19 <u>56</u> , and that death occurred at <u>6:45A</u> M., from the causes and on the date stated above.							
SIGNATURE <u>L.V. Maldve</u>		ADDRESS (Street, city, town, state) <u>L.V. Maldve, M.D.; Deer's Head State Hospital Salisbury, Maryland</u>				DATE SIGNED <u>3/22/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/24/56</u>		NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		LOCATION (City, town, or county) (State) <u>East New Market, Md</u>	
24. REC'D BY REGISTRAR <u>MAR 27 1956</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Luck & Kellough</u>		ADDRESS <u>East New Market</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

1. PLACE OF DEATH

2. TIME

3. DATE

4. SEX

5. AGE

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DEATH CERTIFICATE

13. SIGNATURE OF DEATH CERTIFICATE

14. SIGNATURE OF DEATH CERTIFICATE

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56. SIGNATURE OF DEATH CERTIFICATE

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59. SIGNATURE OF DEATH CERTIFICATE

60. SIGNATURE OF DEATH CERTIFICATE

BUREAU V. S.

MAR 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3466

CERTIFICATE OF DEATH

03417

Dr. Lynch

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. # 2				d. STREET ADDRESS R.D. # 2			
3. NAME OF DECEASED (Type or print) First Ida Middle Belle Last Savage				4. DATE OF DEATH Month March Day 2 Year nd 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1876	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months 4 Days 12	IF UNDER 24 HRS. Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Sussex Co. Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME David B. Tingle				14. MOTHER'S MAIDEN NAME Sarah E. Moore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Alice Layfield (Daughter)			Address R.D. # 3 Delmar Delaware
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure due to general Arteriosclerosis DUE TO Multiple Sclerosis DUE TO Osteo Arthritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 4 yrs 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)	
21. I certify that I attended the deceased from June 20, 1956 , to Mar 7, 1956 , that I last saw the deceased alive on Mar 2, 1956 , and that death occurred at 3:30P M. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. H. Lynch			M.D. Delmar		DATE SIGNED March 5-1956		
PHYSICIAN'S NAME (Type) Dr. S.H. Lynch			M.D. Delmar, Delaware				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 5, 1956	22c. NAME OF CEMETERY OR CREMATORY Melsons Cemetery		22d. LOCATION (City, town, or county) (State) R.D. Delmar Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY			ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR MAR 7 1956	24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completed certificate has been signed by the attending physician and completed. After the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03418

Dr. Lawry

3461

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.D. # 1</u>				d. STREET ADDRESS <u>R.D. # 1</u>			
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> <input checked="" type="checkbox"/> Middle <u>L.</u> XXXXXXXXXX Last <u>SIRMAN</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>18</u> th Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 28, 1872</u>		9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>15</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at own home</u>		11. BIRTHPLACE (State or foreign country) <u>Wicomico Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William Hastings</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Workman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mr. J. Clayton Sirman (Husband)</u> Address <u>R.D. # 1 Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1 Congestive Heart Failure</u> DUE TO (b) <u>1 yr.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>01</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1946</u> , 19 <u>56</u> , to <u>3-13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-13-56</u> , 19 <u>56</u> , and that death occurred at <u>8:15 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lee L. Lawry</u> M.D.				ADDRESS (Street, city or town, state) <u>Fruitland, Maryland</u>		DATE SIGNED <u>Mar. 14 1956</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Lee Lawry</u> M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 18 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nasawango Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury-Snow Hill, Road- Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> *				ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR <u>MARY H. HOLLOWAY</u>	
				24b. REGISTRAR'S SIGNATURE <u>MARY H. HOLLOWAY</u>		DATE <u>19 1956</u>	

CERTIFICATE OF DEATH

PLACE THE CERTIFICATE IN THIS POSITION		MAY 19 1956	
DECEASED		DATE OF DEATH	
PLACE OF DEATH		PLACE OF BIRTH	
MARRIED		SINGLE	
SEX		AGE	
RACE		RELIGION	
EDUCATION		OCCUPATION	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERGY	
SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
SIGNATURE OF CORONER		SIGNATURE OF DISTRICT ATTORNEY	
SIGNATURE OF COUNTY CLERK		SIGNATURE OF STATE CLERK	
SIGNATURE OF HEALTH COMMISSIONER		SIGNATURE OF DEPARTMENT OF HEALTH	

RECEIVED
MAR 19 1956
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3438

CERTIFICATE OF DEATH

03419

Item 2, Film G194 3-23-56 et

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Queen Anne's</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Centreville</u>		17x-20	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>R. R. #, Box 32</u>			
3. NAME OF DECEASED (Type or Print) <u>THOMAS Raymond SKINNER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 16 19 56</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Oct. 26, 1888</u>	9. AGE last birthday <u>67 yrs.</u>	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Richard Skinner</u>				14. MOTHER'S MAIDEN NAME <u>Telitha Ann?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Grace Skinner, Centreville, Maryland</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
155x IMMEDIATE CAUSE (A) <u>Carcinoma of Gall bladder</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1-2 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary Tuberculosis</u>				<u>5-10 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Gall bladder</u>		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-22</u> , 19 <u>56</u> , to <u>3-15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-16</u> , 19 <u>56</u> , and that death occurred at <u>12:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town/state)		DATE SIGNED <u>3-16-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar. 19, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>March 17, 1956</u>		REGISTRAR'S SIGNATURE <u>R. W. Mary J. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	

CERTIFICATE OF DEATH

3228

Reg. No. 124

CAUSE OF DEATH

PLACE OF DEATH

MARYLAND

WYOMING

DELAWARE

PENNSYLVANIA

NEW YORK

NEW JERSEY

CONNECTICUT

MASSACHUSETTS

VIRGINIA

WEST VIRGINIA

KENTUCKY

MISSISSIPPI

LOUISIANA

ARKANSAS

MISSOURI

ILLINOIS

INDIANA

OHIO

PACIFIC COAST

ALABAMA

GEORGIA

FLORIDA

TEXAS

OKLAHOMA

NEBRASKA

KANSAS

MINNESOTA

WISCONSIN

ILLINOIS

INDIANA

OHIO

PACIFIC COAST

ALABAMA

GEORGIA

FLORIDA

TEXAS

OKLAHOMA

NEBRASKA

KANSAS

MINNESOTA

WISCONSIN

ILLINOIS

INDIANA

OHIO

PACIFIC COAST

ALABAMA

GEORGIA

FLORIDA

TEXAS

OKLAHOMA

NEBRASKA

KANSAS

MINNESOTA

WISCONSIN

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OKLAHOMA

NEBRASKA

KANSAS

MINNESOTA

WISCONSIN

ILLINOIS

INDIANA

OHIO

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing it and "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3439

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

034232

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>				c. LENGTH OF STAY IN 1b Hours			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Near Columbia</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Rufus</u> Last <u>Smiley</u>				4. DATE OF DEATH Month <u>3</u> Day <u>2</u> Year <u>19 56</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 10, 1888</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Marvil Package Co.</u>			
11. BIRTHPLACE (State or foreign country) <u>Sharptown, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Levin R. Smiley</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth J. Roberts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>222-09-6382</u>			
17. INFORMANT <u>Lillian A. Smiley, Delmar, Delaware, R.F.D.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>954X</u> IMMEDIATE CAUSE (a) <u>Air embolism during anesthesia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u>Adeno carcinoma of the rectum, pulmonary metastasis</u> DUE TO cause lost. (c) <u>Years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <u>Operation under nitrous oxide anesthesia, colostomy.</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>3-2-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>March 6, 1956</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Zion Church Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Near Sharptown, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>				ADDRESS			
24a. REC'D BY REGISTRAR <u>DATE 3-6-56</u>				24b. REGISTRAR'S SIGNATURE <u>Mary W. Hallonay</u>			

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		AGE _____	
PLACE OF BIRTH _____		OCCUPATION _____		DATE OF DEATH _____	
PLACE OF DEATH _____		CAUSE OF DEATH _____		MANNER OF DEATH _____	
SIGNATURE OF MEDICAL EXAMINER _____		SIGNATURE OF CORONER _____		SIGNATURE OF JURY _____	
CITY _____		COUNTY _____		STATE _____	

BUREAU V. S.

MAR 8 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

034-1

CERTIFICATE OF DEATH

3452

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar		c. LENGTH OF STAY IN 1b 35 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Railroad Avenue Ext.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Nathan Last Smith		4. DATE OF DEATH Month March Day 1 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1880
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Molder		10b. KIND OF BUSINESS OR INDUSTRY Brass	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Smith		14. MOTHER'S MAIDEN NAME Anna Attmore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.# 1		16. SOCIAL SECURITY NO. 220-10-8040	
17. INFORMANT Minnie Smith, Delmar, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 446x DUE TO Ischemic Cornea Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Nephritis & Arterio Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1 , 19 54 , to Mar 1 , 19 56 , that I last saw the deceased alive on Feb 29 , 19 56 , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		DATE SIGNED Delmar Del	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-3-1956	
22c. NAME OF CEMETERY OR CREMATORY First Methodist		22d. LOCATION (City, town, or county) (State) Delmar, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE W.S. Marvel Co - Delmar, Del		24. REC'D BY REGISTRAR DATE 5 1956	
24b. REGISTRAR'S SIGNATURE Harry E. Hudson			

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03422

3440

CERTIFICATE OF DEATH

Reg. Dist. No. 33✓

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Cecil			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury		5 1/2 mos.		TOWN North East		07x-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital				STREET ADDRESS (If rural give location) RFD 2			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) John		(Middle) Robert		(Last) Sullins		(Month) March (Day) 27 (Year) 1956	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
Male	White	Widowed	April 5, 1872	83 yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farming		Farm		North Carolina		USA	
13. FATHER'S NAME UNK				14. MOTHER'S MAIDEN NAME UNK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Unk.		--		Hospital Records Robert Sullins (Son)			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Arteriosclerotic cardiovascular disease				North East, Md.		4 years	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerosis general and cerebral						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Chronic brain syndrome associated with senility		?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 11, 1955 , to March 27, 1956 , that I last saw the deceased alive on March 27, 1956 , and that death occurred at 2:10 PM , from the causes and on the date stated above.							
SIGNATURE H. Juerman		M.D. Deer's Head State Hospital, Salisbury		DATE SIGNED 3/27/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY, OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		3-31-56		FRAYSIER Family Cem		Near Blackmore VA. Scott Co.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
VS AISC 1-55 10M		Mary H. Holloway		Holloway Company		Salisbury Md.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Date of Death

Place of Death

Age

Sex

Color

Marital Status

Occupation

Education

Religion

Usual Residence

Place of Birth

Date of Birth

Place of Birth

Date of Birth

Place of Birth

Date of Birth

Place of Birth

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3-31-56
Hollister Company - 241 Bedford St.
Hollister Company - 241 Bedford St.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN-OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3441

CERTIFICATE OF DEATH

03423

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>104 VAN BUREN STREET</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Sullivan</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 7 1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Newborn</u>	8. DATE OF BIRTH <u>March 7, 1956</u>	9. AGE last birthday yrs. <u>3</u>		IF UNDER 1 YEAR: Months <u>3</u> Days <u>20</u> IF UNDER 24 HRS. Hours <u>3</u> Min. <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Wesley Sullivan</u>				14. MOTHER'S MAIDEN NAME <u>Marie Sobolowsky</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
773.5 IMMEDIATE CAUSE (A) <u>Heart failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 hours 20 min</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Extreme prematurity (18 week conception)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that attended the deceased from <u>3/7/1956</u> to <u>3/7/1956</u> , that I last saw the deceased alive on <u>3/7/1956</u> , and that death occurred at <u>4:50 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state)		DATE SIGNED <u>March 9th 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>Mar. 9-56</u>		NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital & Salisbury, Wicomico, Md</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary W. Holloran</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital</u>		ADDRESS	
DATE <u>3-9-56</u>							

CERTIFICATE OF DEATH

1. PLACE OF DEATH

2. PLACE OF BIRTH

3. NAME OF DECEASED

4. SEX

5. AGE

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CLERK

15. SIGNATURE OF DECEASED

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF REGISTRAR

18. SIGNATURE OF PHYSICIAN

19. SIGNATURE OF CLERK

20. SIGNATURE OF DECEASED

21. SIGNATURE OF WITNESSES

22. SIGNATURE OF REGISTRAR

23. SIGNATURE OF PHYSICIAN

24. SIGNATURE OF CLERK

25. SIGNATURE OF DECEASED

26. SIGNATURE OF WITNESSES

27. SIGNATURE OF REGISTRAR

28. SIGNATURE OF PHYSICIAN

29. SIGNATURE OF CLERK

30. SIGNATURE OF DECEASED

31. SIGNATURE OF WITNESSES

32. SIGNATURE OF REGISTRAR

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3442 **CERTIFICATE OF DEATH**

03424

Dr. Wm H. Fisher Jr.

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Quantico</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>In Village</u>			
3. NAME OF DECEASED (Type or Print) <u>OLA</u>		(First) <u>MAY</u>		(Last) <u>Taylor</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>20</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 23, 1894</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>27</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at own home</u>		11. BIRTHPLACE (State or foreign country) <u>Quantico Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Cadmus Bailey</u>				14. MOTHER'S MAIDEN NAME <u>Mary Reddish</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. A. Carlton Taylor (Husband) Quantico Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
585X IMMEDIATE CAUSE (A) <u>Pulmonary embolism</u>				INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Phlebotomy lacer. left leg</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Acute cholecystitis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>3-8-56</u>		19b. MAJOR FINDINGS OF OPERATION <u>Acute cholecystitis</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., 9:30 A.M., from the causes and on the date stated above.							
SIGNATURE <u>William H. Fisher Jr.</u>				ADDRESS (Street, city, town, state) <u>Salisbury Md.</u>		DATE SIGNED <u>Mar. 20 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar. 22, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Quantico Methodist Cemetery</u>		LOCATION (City, town, or county) (State) <u>Quantico, Maryland</u>	
24. REC'D BY REGISTRAR <u>MAR 22 1956</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	

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CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince George's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>13 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Laurel</u>		<u>16 x 2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>Route # 2 Laurel-Bowie Road</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Margaret Myra Trombley</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 27 19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3/13/1897</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Kiley</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Generalized carcinomatosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Ca. of breast and uterus</u>						<u>12 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/28</u> , 19 <u>55</u> , to <u>3/27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/27</u> , 19 <u>56</u> , and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>L.V. Maldve, M.D.</u>		ADDRESS (Street, city, town, state) <u>Deer's Head Hospital Salisbury, Maryland</u>		DATE SIGNED <u>3/27/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar. 30, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>St Joseph Cemetery</u>		LOCATION (City, town, or county) (State) <u>Monroe, Mich.</u>	
24. REC'D BY REGISTRAR DATE <u>MAR 29 1956</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

3128

1956

1. NAME OF DECEASED

2. SEX

3. DATE OF BIRTH

4. PLACE OF BIRTH

5. OCCUPATION

6. CAUSE OF DEATH

7. PLACE OF DEATH

8. TIME OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF CHURCH

15. SIGNATURE OF BURIAL SOCIETY

16. SIGNATURE OF CEMETERY

17. SIGNATURE OF INTERVIEWER

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BUREAU V. S.

MAR 29 1956

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 15

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completed certificate filled in by the funeral director, TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3444

CERTIFICATE OF DEATH

03426

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MD</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury MD</u> c. LENGTH OF STAY IN lb <u>40 yrs</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury MD</u> d. STREET ADDRESS <u>Jersey Rd P.F. #2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ernie</u> First <u>Dwight</u> Middle <u>Lee</u> Last 4. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>1956</u>		5. SEX <u>female</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1898</u> 9. AGE (In years last birthday) <u>38</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> 11. BIRTHPLACE (State or foreign country) <u>Pocomoke Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Boston</u> 14. MOTHER'S MAIDEN NAME <u>Henry Tull Sr.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>3</u> 17. INFORMANT <u>Henry Tull Sr.</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X</u> <u>Assepsia</u> DUE TO <u>Renal Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renal Hypertension</u> DUE TO (c) <u>Renal Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 Mar. 1956</u> to <u>5 Mar. 1956</u> , that I last saw the deceased alive on <u>5 Mar. 1956</u> , and that death occurred at <u>3:30</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>E. A. Purnell</u> M.D. ADDRESS (Street, city or town, state) <u>652 W Main St, Salisbury MD</u> DATE SIGNED <u>9 March 56</u> PHYSICIAN'S NAME (Type) <u>E. A. PURNELL, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>3-11-56</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u> 22d. LOCATION (City, town, or county) (State) <u>Salisbury MD</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. Work</u> ADDRESS <u>Salisbury MD</u> 24a. REC'D BY REGISTRAR DATE <u>3-13-56</u> 24b. REGISTRAR'S SIGNATURE <u>Walter D. Hollomay</u>	

RECEIVED

W. A. Parnell, M.D.

Henry B.

15th Nov 20 22

BUYER

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03427

3445 CERTIFICATE OF DEATH

Reg. Dist. No.

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|--|-------------------------------|--|---------------------------------------|--|--------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Wicomico</u> | | MARYLAND | | STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>SALISBURY</u> | | <u>6 DAYS</u> | | TOWN <u>Pocomoke</u> | | <u>23-42-2</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u> | | | | STREET ADDRESS (If rural give location) <u>1406 LINDEN DRIVE</u> | | | |
| 3. NAME OF DECEASED
(Type or Print) <u>WILLIAM H. WATSON</u> | | | | 4. DATE OF DEATH (Month) <u>MARCH</u> (Day) <u>5</u> (Year) <u>1956</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>JUNE 22, 1983</u> | 9. AGE last birthday <u>72</u> yrs. | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES CLERK</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>STATE LIQUOR STORE</u> | | 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>JOHN WATSON</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY ELLEN THORNTON</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>216-01-8634</u> | | 17. INFORMANT & ADDRESS <u>MRS ETHEL N. WATSON, Pocomoke, MD.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 150X IMMEDIATE CAUSE (A) <u>Coronary Artery Thrombosis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Atherosclerosis</u> | | | | <u>Unknown</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Carcinoma of Esophagus with metastasis to the lung</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>3-25</u> , 19 <u>56</u> , to <u>3-5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-5</u> , 19 <u>56</u> , and that death occurred at <u>2 P.</u> M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>David J. Gilmore</u> | | | | ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u> | | DATE SIGNED <u>3/5/56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | DATE THEREOF <u>3-7-56</u> | | NAME OF CEMETERY OR CREMATORY <u>PARKSLEY CEMETERY</u> | | LOCATION (City, town, or county) (State) <u>PARKSLEY, VIRGINIA</u> | |
| 24. REC'D BY REGISTRAR <u>MAR 8 1956</u> | | REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u> | | ADDRESS <u>Pocomoke Md.</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete the certificate. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete the certificate. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9, Film G1944-2-56 et

3446

CERTIFICATE OF DEATH

03428

Reg. Dist. No. 332

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|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Wicomico</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>
c. LENGTH OF STAY IN 1b <u>Life</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>92 Gen Sew Hosp</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD</u>
b. COUNTY <u>Wicomico</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury MD</u>
d. STREET ADDRESS <u>152 Del Ave</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Oliver</u> First <u>Weatherly</u> Middle <u>W</u> Last <u>W</u> | | | | 4. DATE OF DEATH
Month <u>3</u> Day <u>18</u> Year <u>1956</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>C</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Unknown</u> Approx. <u>68</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | | 11. BIRTHPLACE (State or foreign country) <u>Somerset Co</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>?</u> | | | | 14. MOTHER'S MAIDEN NAME <u>?</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>173-10-7578</u> | | 17. INFORMANT <u>Laura Weinwright</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
<u>145X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Tonsil</u>
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>7 days</u>
<u>18 mos</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour a. p. m. _____
Month, Day, Year _____
19 _____ | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from <u>7-8</u> , 19 <u>55</u> , to <u>3-18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-18</u> , 19 <u>56</u> , and that death occurred at <u>10:15</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL PHYSICIAN'S NAME (Type) <u>John M. Bledsoe III</u> | | | | ADDRESS (Street, city or town, state) <u>M.D. Medicine Center Salisbury Md</u>
DATE SIGNED <u>3-26-56</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>3/22/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Monrovia Cem</u> | | 22d. LOCATION (City, town, or county) <u>Monrovia Md</u> (State) _____ | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M West</u> ADDRESS <u>Salisbury Md</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE 3-27-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u> | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|------------------------|--|--------------------|--|--------------------------|--|------------------------|--|--------------------|--|---------------------------|--|--------------------------------|--|--------------------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES H. HARRIS | | 65 | | M | | W | | JAN 15 1891 | | BALTIMORE, MD | | JAN 29 1956 | | BALTIMORE, MD | |
| OCCUPATION | | EDUCATION | | MARRIAGE | | RELIGION | | CAUSE OF DEATH | | MANNER OF DEATH | | PERMANENT RESIDENCE | | TEMPORARY RESIDENCE | |
| Carpenter | | High School | | Married | | Roman Catholic | | Heart Disease | | Natural | | 1234 E. Baltimore St. | | | |
| PREVIOUS ILLNESS | | DATE OF ONSET | | DATE OF LAST EXAMINATION | | DATE OF LAST TREATMENT | | DATE OF LAST VISIT | | DATE OF LAST CONSULTATION | | DATE OF LAST MEDICAL ATTENTION | | DATE OF LAST NURSING ATTENTION | |
| None | | Jan 20 | | Jan 25 | | Jan 28 | | Jan 29 | | Jan 29 | | Jan 29 | | Jan 29 | |
| TREATMENT | | NURSING | | HOSPITAL | | PHYSICIAN | | NURSE | | CHAPLAIN | | CLERGYMAN | | OTHER | |
| None | | None | | None | | None | | None | | None | | None | | None | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF NURSE | | SIGNATURE OF CHAPLAIN | | SIGNATURE OF CLERGYMAN | | SIGNATURE OF OTHER | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESSES | | SIGNATURE OF REGISTRAR | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

BUREAU V. S.

MAR 29 1956

RECEIVED

1. This certificate is to be filled out by the physician or other person who has attended the deceased during his last illness. It should be filled out as soon as possible after death, and before the body is buried or cremated. It is a legal document and its contents are subject to the laws of the State of Maryland. It is the duty of the physician or other person who has attended the deceased to fill out this certificate truthfully and accurately. It is the duty of the registrar to receive this certificate and to enter it in the death register. It is the duty of the registrar to issue a death certificate to the family of the deceased. It is the duty of the registrar to keep the death register for a period of ten years. It is the duty of the registrar to make the death register available to the public for a period of ten years. It is the duty of the registrar to make the death register available to the public for a period of ten years.

DATE MAR 19 1956

RECEIVED

9551

0.237

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete the certificate. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete the certificate. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03430

3448

CERTIFICATE OF DEATH

Reg. Dist. No.

332

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Wicomico</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Riverside Nursing Home</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Lelia Alice Wilkinson</u> | | | | 4. DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>1956</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>May 19, 1863</u> | |
| 9. AGE (In years last birthday) <u>92</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Delaware</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | 13. FATHER'S NAME <u>Spicer Truitt</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Unknow</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. <u>None</u> | | | | 17. INFORMANT <u>Mrs. C. Myron Dashiell, Same</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
DUE TO <u>Hypertension</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u>
DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u>19</u> p. m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>1946</u> , 19 <u>56</u> , to <u>3/15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/15</u> , 19 <u>56</u> , and that death occurred at <u>8:18 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Fred R. Gramse</u> M.D. <u>Salisbury, Md</u> | | | | ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> | | | |
| DATE SIGNED <u>3-17-56</u> | | | | DATE SIGNED <u>3-17-56</u> | | | |
| 18. ACTUAL SIGNATURE <u>Dr. Fred R. Gramse</u> M.D. <u>Salisbury, Md</u> | | | | | | | |
| 19. NAME (Type) <u>Dr. Fred R. Gramse, 402 South Division St., Salisbury, Maryland</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>3/17/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Hebron Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Hebron, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Maryland</u> | | | | 24a. REC'D BY REGISTRAR <u>Norman T. Baker</u> | | | |
| 24b. REGISTRAR'S SIGNATURE <u>Mary Ann Holloway</u> | | | | DATE <u>3-17-56</u> | | | |

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03431

3449 **CERTIFICATE OF DEATH**

Dr. Gramse Item 2, Film G195 h-12-56 et

Reg. Dist. No.

| | | | | | | | |
|--|-------------------------|---|---|---|---|---|-------------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Wicomico</u> | | STATE <u>MARYLAND</u> | | STATE <u>Maryland</u> | | COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Salisbury</u> | | <u>1950 at Home</u> | | TOWN <u>Salisbury (John B. Parsons Home)</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hospital</u> | | | | STREET ADDRESS <u>XXXXX Beyond Hwy East Street</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>GERTRUDE</u> <u>WILLIS</u> | | | | <u>MARCH</u> <u>30th</u> <u>19 56</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Female</u> | <u>White</u> | <u>Widowed</u> | <u>April 6, 1869</u> | <u>86</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| <u>House Work (Retired)</u> | | | <u>None</u> | | <u>Dresdon, England</u> | | <u>U S A</u> |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>John Soulsby</u> | | | | <u>Anna Walker</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | |
| <u>NO</u> | | | | | <u>Records of John B. Parsons Home for Aged Salisbury, Maryland</u> | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| <u>332X</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) | | | | | | <u>Cerebral Thrombosis</u> | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | | |
| STATING UNDERLYING CAUSE LAST. | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | |
| | | | While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | |
| 22. I hereby certify that I attended the deceased from <u>3:00</u>, 19 <u>56</u>, to <u>3:30</u>, 19 <u>56</u>, that I last saw the deceased alive on <u>3/30</u>, 19 <u>56</u>, and that death occurred at <u>8:15P.</u> M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | DATE SIGNED | | | |
| <u>Dr. Fred Gramse</u> | | | | <u>Mar 31 1956</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 24. REC'D BY REGISTRAR | | | |
| <u>Burial</u> | | | | <u>Mary H. Holloway</u> | | | |
| 25. FUNERAL DIRECTOR'S SIGNATURE | | | | ADDRESS | | | |
| <u>HOLLOWAY & COMPANY</u> | | | | <u>SALISBURY MARYLAND</u> | | | |

APR 4 1956

BUREAU V. S.

APR 4 1956

RECEIVED

3. 11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

3463

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03432

Reg. Dist. No. 332

| | | | |
|--|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH-
COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED-
STATE <u>Maryland</u> COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN <u>Salisbury</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural, give location)
<u>Anderson Road, Route 5</u> | |
| 3. NAME OF DECEASED (First) <u>Elizah</u> (Middle) <u>M.</u> (Last) <u>Young</u> | | 4. DATE OF DEATH (Month) <u>March</u> (Day) <u>1st</u> (Year) <u>1956</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>C</u> | 7. SINGLE, MARRIED,
WIDOWED, SEPARATED,
(Specify) | 8. DATE OF BIRTH <u>Dec. 25 1881</u> |
| 9. AGE last birthday <u>74</u> yrs. | | 10. If under 1 year: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Reporter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Accomack County, Va</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>John Young</u> | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth Young</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY No. | |
| 17. INFORMANT AND ADDRESS
<u>Wm C. Robinson - Salisbury, Md.</u> | | 18. INFORMANT AND ADDRESS <u>Rte. 5 (Anderson Road)</u> | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral Hemorrhage

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

| | | | | |
|---|---|-----------------------|----------|---------|
| 21. ACCIDENT (Specify)
SUICIDE
HOMICIDE | PLACE (Home, farm, factory, street, office bldg., etc.)
INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? | | |

22. I hereby certify that I attended the deceased from Feb. 26, 1956, to March 1, 1956, that I last saw the deceasedalive on March 1, 1956, and that death occurred at 9:00 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

| | | | | |
|---|-------------------------|-------------------------------|----------------------------------|-----------------|
| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
| <u>Burial</u> | <u>3/4/56</u> | <u>Household Rufts</u> | <u>Accomack</u> | <u>Virginia</u> |
| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS | |
| <u>3-2-56</u> | <u>Mary W. Holloway</u> | <u>J. Edgar Thomas</u> | <u>Accomack, Virginia</u> | |

RECEIVED

MAR 5 1956

BUREAU V. S.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete the certificate filled in by the funeral director, TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and complete the certificate filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Gramse

3450

CERTIFICATE OF DEATH

Reg. Dist. No.

03433

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Salisbury | | c. LENGTH OF STAY IN 1b
1 day | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Pen. Gen. Hospital | | d. STREET ADDRESS
Edgar Drive & Lincoln Ave | |
| 3. NAME OF DECEASED
(Type or print)
First GEORGE Middle WASHINGTON Last YOUNG | | 4. DATE OF DEATH
Month March Day 23rd Year 1956 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 29, 1876 |
| 9. AGE (In years last birthday) yrs. 79 | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
Retired | |
| 11. BIRTHPLACE (State or foreign country)
Elliott Island Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
John Young | | 14. MOTHER'S MAIDEN NAME
Rebecca Smith | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) Unk (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mrs. Mammie Young (Wife) Address Edgar Drive & Lincoln Ave. Salisbury, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
331X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH
24 hrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3/22 , 19 56 , to 3/23 , 19 56 , that I last saw the deceased alive on 3/23 , 19 56 , and that death occurred at 6:15 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) S. Division St. Salisbury, Maryland DATE SIGNED March 25 1956
ACTUAL SIGNATURE F. R. Gramse M.D.
PHYSICIAN'S NAME (Type) D r. Fred Gramse M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Mar. 26, 1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Parsons Cemetery | | 22d. LOCATION (City, town, or county) (State)
Salisbury, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
HOLLOWAY & COMPANY * | | 24a. REC'D BY REGISTRAR
SALISBURY MARYLAND | |
| 24b. REGISTRAR'S SIGNATURE
Mary H. Holloway | | DATE
MAR 27 1956 | |

MASSACHUSETTS DEPARTMENT OF HEALTH - BELLINGHAM 18

MAR 27 1956

RECEIVED